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# THE MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. I.—3RD YEAR—NO. 15. SYDNEY: SATURDAY, APRIL 8, 1916. PRICE 6D.

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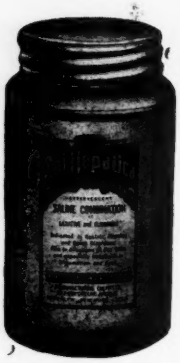

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—3RD YEAR. SYDNEY: APRIL 8, 1916. No. 15.

## An Address.*

Delivered by

**George Armstrong, M.B., B.S. (Melb.),**

*Retiring President of the New South Wales Branch of the British Medical Association.*

Since our last annual meeting we have lost some of our oldest and best known members. By the unexpected death of Dr. W. Odillo Maher, the profession has been robbed of one of its most distinguished members, and the community has lost a prominent citizen. As an ophthalmic surgeon he had reached a high position; his name was famous throughout this State, and beyond its limits. He was quiet and unassuming in manner, but the thorough way in which he carried out every detail of his work and the brilliance, originality and dexterity of his operative measures soon impressed you with the fact that he was a master of his art.

Dr. Johnson, of Parkes, held a high place in the esteem of the people in the district, where he had practised for many years, and the brave fight he put up against a painful malady for so long showed that he was of the stuff of which heroes are made.

Dr. Lamrock, of the Illawarra suburbs, was well known to many of our members. He was a fine type of medical man, and will be much missed in the district where he had practised.

Dr. Muir Smith—one of our most promising and distinguished young graduates—gave his life for his country at Gallipoli. He had expert knowledge and experience as a signaller, and he was serving in this capacity when he fell a victim to the Turks. It is at once one of the tragedies and glories of this wretched war, that such a useful and valued life should be closed at the very threshold of what promised to be such a successful career.

The year 1915 just ended has been a disturbed one all over the world, more particularly in British countries. National and Imperial interests have loomed so largely that mere personal interests have been overshadowed. Your Council has been materially reduced in strength, owing to the departure for the war of Drs. Craig, Dick, Jamieson, Read and Thomas, and of Dr. Scot Skirving for England. Whilst we have missed them very much from our deliberations, we are proud to know that they have done such good work in the service of the Empire. As this has been the first year in which the executive work of the Branch has been carried on by standing committees, with infrequent meetings of the full Council, a quorum has sometimes been difficult to procure, with the result, in my opinion, that the general interest in the whole work of the Council has not been as well sustained as in former years. I am so convinced of this that I would suggest that the full Council should meet more frequently, so that each member would be kept in closer touch with every phase of the work.

### Progress.

The Branch for some years past has been progressive, as evidenced by increased membership and the absence of radical reform proposals, until the latter were found necessary as the result of certain proprietary and public movements, calculated to affect the best interests of the profession.

These radical and reform changes include—

(1) Increase in the number of councillors.
(2) Establishment of local associations.
(3) Establishment of standing committees of the Council.
(4) The meetings of delegates of local associations with the Council.
(5) Changes in the character of our journal, with the appointment of a special editor, and the federalizing of the paper.

The proprietary and public movements calling for this increased machinery on our behalf have been:—

(1) The Friendly Societies' organizations.
(2) Nationalization of medicine movements on the part of the State Ministry.

The adoption of the Common Form of Agreement has ensured us victory in some quarters in the so-called "Battle of the Clubs"; and the members will be pleased to learn that most of the lodges throughout the State, including some of the most troublesome ones, have, during the year, come under this agreement. This has benefited many members of the profession greatly, not only in the monetary sense, but in the feeling that they are working under fair conditions, and in the knowledge that in any dispute their destiny does not depend on the arbitrary decision of a few busybodies in any one lodge. In addition, they have the support of their professional brethren in any unjust decision that may be given against them.

A firm attitude has had to be adopted by the Council to resist encroachments on our interests by certain Government Departments.

The decisions of the Council have been duly fortified by resolutions submitted to general meetings of members of the Branch. In spite of protests, the Government is steadily pushing on with their various works. The establishment of night venereal clinics has meant a considerable reduction in the incomes of a large number of our members, and one is tempted to doubt whether the scrutiny of the financial position of the applicants for treatment at these clinics is as searching as it should be. The members of the Branch were aroused by advertisements appearing in our journal early in the year, asking for applicants for Government positions in various special departments. It is a well-known fact that many of our affluent people take advantage of the State Education Department. Unless we reso-

* Read before the Annual Meeting of the New South Wales Branch of the British Medical Association on March 30, 1916.

lutely refuse to allow ourselves to be exploited, these same people will be only too willing to take full advantage of a State medical service.

A more recent development of the tendency of the present authorities in the direction of the nationalization of medicine is the effort of the Minister of Public Instruction to establish school clinics for treatment of special diseases, and he has stated definitely that there will be no discrimination or inquiry into the circumstances of the parents or guardians of the children.

The profession has already expressed its opinion, and has decided that its members should not accept such appointments. This action will no doubt be considered mercenary by the Minister. Unfortunately, we have to pass resolutions, which may be misinterpreted, in order to check growing evils; it can, however, without any exaggeration, be proved that, apart from being against the interests of medical men, the proposed methods of treatment will be prejudicial to the health of the children, and, therefore, against the public welfare. Dr. Pockley's recent speech on the subject, and the correspondence following in the public press, has proved this amply, and has gone to show that if the Minister for Public Instruction is in earnest in regard to the welfare of deserving school children, we might ask him first to adopt measures to prevent disease and to conserve the health of the pupils in the direction where this has already been found necessary, instead of attempting to obtain cheap popularity by giving free treatment in cases requiring special knowledge, long experience and skill, by necessarily inexperienced medical officers.

The Commission appointed to report on tuberculosis in 1913, found that the Department of Public Instruction had not attended to many sanitary essentials, especially in regard to inadequate air space and lavatory conveniences. These evils have not been remedied, and it is strange but true that the Department is exempt from the operations of the Public Health Act.

It is well for the public to know these facts, before being unduly influenced by the so-called philanthropy of a State Minister, who is pretending to establish by an inefficient State medical service, what is already provided for by medical men in the front rank of their profession to deserving cases free of cost to the public.

The establishment of a definite attitude to these burning questions has entailed a large amount of extra work; to effect it all it has necessitated an increase of our staff and its emoluments, and, in consequence, an increase in the amount of the annual subscription of members.

The increase in the membership has not been as satisfactory as we should wish, in view of the fact that a very large number of men have graduated from the Sydney University during the year. This can only be regarded as unsatisfactory, and if the Branch is to continue its onward progress, it behoves every member to put his shoulder to the wheel to induce old members to retain their membership and new members to join the Branch. I would urge every member to try and secure one new member during the present year.

One is tempted to inquire into the cause of the unsatisfactory increase in the membership. Is it because of the increase in the subscription? Four guineas is a very moderate amount for the benefits that the Branch affords. It must be the aim of the Branch to have every eligible man in its ranks, otherwise we cannot hope to deal effectively with the problems that are constantly confronting us.

The relation of *The Medical Journal of Australia* to the policy of the New South Wales Branch of the British Medical Association has been a source of anxiety during the past year. One editorial led to a general meeting being called, and the result clearly showed that the *Journal's* policy was not in sympathy with the views of the members. The attack on the present Minister of Public Health in the *Journal* of December 25, 1915, was as unwise as it was unwarranted, as Mr. Black, since his acceptance of office, had left the medical profession alone to carry out its work in its own way; the article was especially indiscreet, when it went on to compare the Minister, to his disadvantage, with his predecessor in office, who was constantly bringing forward new schemes that were inimical to the best interests of the profession. Further, there was a strong feeling among a large number of our members, who were in a position to know, that the article was inspired, and that the *Journal* was made use of to further a political intrigue, and for no good medical purpose whatever.

The *Journal* is controlled by the Directors of the Australasian Medical Publishing Company. Each Branch in the various States elects three members, one of whom is appointed Director. The *Journal* has been established on a federal basis, and it is confidently hoped that the New South Wales Director will make further endeavours to see that the views of the New South Wales Branch are more faithfully reflected in the *Journal* in the future than they have been in the past. We look to the tone of its articles as being inspired by the opinion of the majority of those interested, and we expect it to take a strong stand in the interests of right and independence on all questions involving the welfare of the profession. It would be useless to try and hide the fact of the murmurings of discontent with the *Journal*. We ask our Director to find the cause of the trouble, and to remedy it. The *Journal* is an important asset of the Branch, and we must use every endeavour to see that its value is not depreciated.

### Standing Committees.

I feel convinced after an experience of a year, that the work of the Branch would be more efficiently and thoroughly carried out if the system of dividing the Council into Standing Committees was abolished; if the Council is too unwieldly, it would be better to reduce the number of its members. Under existing conditions, we have the Council, divided into various Committees, constituting a kind of inner council, and then, in one instance, we have further an inner council of this second council, the Medical Journal Sub-Committee being an inner council of the Execu-

tive and Finance Committee. As two of these committees usually meet on the same evening, the Honorary Secretary has to try to be in two places at the one time. When the minutes of these committees are read at the quarterly meeting of the Council, there is not sufficient time for important matters to be thoroughly discussed, as a large number of the members are not conversant with the important details of subjects dealt with by committees of which they are not members. After all, the whole Council is responsible to the members, and if it is to be subject to criticism, it should have the opportunity of dealing with matters in full, and not in the form of a report from a smaller section or sub-section of the whole. This criticism of members is wholesome, and is always welcome, but in view of the forces arrayed against the profession at the present time, as far as one can judge, the strength of the attack is likely to be increased. I would therefore suggest to our members that all criticism should be constructive, and not destructive in character; differences of opinion we must have, but let us come together at general meetings, air our grievances before each other, and try to arrive at decisions after full discussion, which will be to the greatest advantage to the general public and to ourselves. We can then stand loyally to these decisions, and do our utmost to carry them to a successful issue.

We should do all we can to relieve any member of any disability from which he may temporarily suffer owing to any resolution of the general body of the members.

### The War.

No President could vacate the chair without remarks under the above heading, apart from the special committees that have been formed, and the representation on various bodies that your Council has been called to make. There has been a vast amount of work done to help in this crisis, and to conserve the interests generally of those who have left their practices to fulfil their part in the great Armageddon. Our members have been most active; the leaders of the profession have gone to all parts of the Empire; at home, members have sacrificed their practices to take military duty, so that younger men might be free to go to the front.

The Honorary Secretary and his office staff have done most valuable work in compiling a census of the members who would be willing to work in various capacities for the military authorities, and the Council has always been ready to advise the Defence Department whenever they have been approached. The members have heard of this from time to time, and have had indicated to them the various avenues in which their services could be utilized. The response for active and home service has been almost universal.

The Council was asked to submit a report on the Liverpool Camp site, and formed part of a committee with leading members of the profession. This joint committee held many meetings, and made recommendations based on sound principles, which, if carried out, will be of great benefit to the health and general welfare of the soldiers.

A compliment was paid to the Branch by the Defence Authorities when they asked your President to form one of a committee to select the Principal Medical Officer of this State, the other three selectors holding office under the Defence Department. We are glad to feel that the importance of the Branch has been recognized, and that we have been of use. We must remember that every individual who strives to do his utmost in the midst of these stirring times does his share in winning the war. The collective energy and virility resulting from such individual effort will form one of the pillars of strength to our nation in this time of pressing need.

Ladies and gentlemen, I hope I have not wearied you, but to review the work of the year covers a lot of ground. We are told that we are a close corporation and a mercenary body, which only moves when our pockets are touched. We shall leave the verdict on that point to be given by the public.

Had the British Medical Association been mercenary in its aims, how would the sick poor have received their medical, surgical and special treatment for generations past? The profession as a whole is less insured against sickness, calamity and disability of advancing years than any other class of the community, and this Association has the right, nay, the duty, to provide for the future of its members. Some scheme of insurance against sickness, accident or other inability to practice might with advantage be instituted by our Branch. The Haviland Hall scheme in Great Britain is a great success and has been a boon to many. I had intended to make some such scheme the subject of my presidential address, but realized that the time was inopportune, and abandoned the idea. However, I trust when the war is ended and our Empire is founded on a more solid and enduring basis than ever, such a scheme will be carried to a successful issue.

## GLANCING BULLET WOUNDS OF THE SKULL:

### A Record of a Series of Cases, with Their Symptoms, After Effects and Treatment.

By **Geoffrey Owen, M.D. (Melb.),**

*Captain, A.M.C., A.I.F., County of London War Hospital, Epsom, England; Surgeon to Camperdown Hospital, Victoria.*

During the last six months, while working in the surgical wards of the Australian Hospital at Harefield, and of the County of London War Hospital at Epsom, it has been my good fortune to have under my care a considerable number of cases which come within the above named category. These cases are of very considerable interest, both from a surgical and neurological point of view, and they illustrate to some extent some of the new features of head injuries met with in modern warfare. It has been suggested to me to send a record of these cases to *The Medical Journal of Australia*, in the hope that they may prove of some interest to the profession. None of these patients, whose histories form the basis of this paper, were seen by me at the time of their original injury. In fact, in the majority, some time,

varying from one to four months, had elapsed since they were wounded, and in nearly all of them the original wounds in the scalp were completely healed before they were operated on. Many of the patients came from Gallipoli, and had been brought home to England in the various hospital ships, and afterwards transferred to Harefield and Epsom from other military hospitals scattered all over England. In all, I have operated on twenty-nine of these patients, and in nearly every case the conditions found proved of the greatest interest both from a neurological and surgical point of view. Up to date, the results obtained have been most encouraging. At the same time, it must be acknowledged that in order to study these cases thoroughly, it would be necessary to take the condition of the various patients in twelve months' time into consideration. I have kept the addresses of the Australian soldiers, and hope to try and follow their fortunes after the war, but it must necessarily be a difficult matter to trace them under the conditions of change which will ensue.

Head injuries of varying types form a considerable proportion of the wounds met with in this war; in trench warfare they are of frequent occurrence. In many cases instant death, or a fatal result after a few hours from hæmorrhage and destruction of vital centres follows; frequently perforating bullet injuries are met with, with a wound of entrance on one side and of exit on the other, the resulting mischief depending on the area of brain traversed by the bullet. Then, again, there are cases with very extensive wounds of the skull, with immense destruction of bone and exposure of large areas of sloughing brain. None of these cases are dealt with in this article. The type of injury to which I will draw attention is that caused by a bullet which inflicts a glancing injury on the scalp and outer table, and, by reason of its velocity and high explosive force, causes an extensive injury to the inner table of the skull, greater than anything which we have been led to recognize before in civil practice. We have long known that slight depressions of the outer table of the skull are frequently associated with much greater injury to the inner table, but in the case of modern bullet wounds this discrepancy is increased to a marked extent. Extensive injury to the inner table, with hardly any evidence of outer table damage, often only a slight depression or groove, is met with. In several cases there was nothing to be seen until the trephine demonstrated the marked injury on the dural side of the skull cap. It is necessary in considering these injuries to recognize the result of the high explosive force of the modern bullet in the underlying brain and its delicate formation of nerve cells and fibres. Of course, in many cases, these structures are injured or pressed upon by detached or projecting fragments of the inner table, by dural or cortical hæmorrhages of traumatic origin; but in other cases where none of these gross lesions are to be demonstrated, clinical evidence of cerebral damage is present, and I think there can be little doubt that the condition is due to the shock of the explosive force transmitted through the skull to the underlying cerebral tissue. In two of the cases reported below this appears to me to be the only possible explanation of the clinical condition and appearances found at the operation.

The question of the effect of high explosives and high velocity bullets on nerve tissue forms a fascinating study, and there have been vast opportunities in this war of studying these cases in large numbers. It has been proved that, quite apart from actual trauma, as produced by physical contact, the passage of a modern bullet may produce a condition of nerve shock on any surrounding nervous elements. For example, a bullet wound through the back of the arm may be followed by complete paralysis of all the muscles supplied by the musculo-spiral nerve, and well-marked reaction of degeneration in these muscles, and yet the nerve, when exposed, may be seen to be quite normal in appearance and intact throughout its whole length, although it does not react to the faradic current applied directly. The nature of this nerve shock remains to be studied in further detail. Beyond doubt, some cases are associated with multiple microscopical extravasations of blood throughout the different nervous tissue involved. This condition is well seen in cases of death from high explosives, in which the brain and spinal cord show these extravasations in a marked degree. I am led to believe that many of these glancing bullet wounds of the head are associated with some similar microscopical changes in the underlying brain tissue, and that in some of these cases this condition may be associated with very little injury to the overlying bone.

The symptoms and signs of these injuries may be divided into two periods—the immediate and the later clinical manifestations.

(1) Immediate.—The infliction of the head wound in nearly every case has been followed by a period of unconsciousness lasting from a few minutes to several days, the return to consciousness being attended by severe headache, and frequently with evidence of interference with some function of the cerebral cortex. In many cases there is at first a well marked hemiplegia, which gradually loses its complete character, and becomes limited to a slight weakness of one limb, one side of the face, or one field of vision.

(2) Later Effects.—A study of these symptoms and signs constitute the most important feature of this group of cases. Headache must be looked on as the outstanding and most marked symptoms of this type of head injury. It is often constant and severe, characterized by attacks of intense aggravation of the pain, which completely prostate the patient. In some cases attacks of vomiting were met with, but in no single instance was optic neuritis noted. I examined the discs carefully in every case. The neurological signs varied in the different cases, according to the wound area, and will be plainly recorded in the clinical histories which follow. The signs of local head injury at the time of the patients' examination in England were very slight. It may be said that the cases were characterized by a scar of varying length in the scalp, generally associated with some local tenderness on pressure. In some cases a definite irregularity or slight guttering of the outer table could be felt, but this was not by any means always

present. In many of the patients the external sign of injury was limited to the scar in the scalp, and that only, and it was very difficult to conceive of the great damage which was found so frequently underneath the apparently innocent scar. Apart from the evidence obtained by a careful and thorough neurological examination, the most promient feature of these cases is severe and persistent headache. The general condition of the patients was usually good, but their mental state in nearly every instance was characterized by some irritability and slow mentality, and in several by a general tremulousness, such as are so frequently seen in severe cases of shell shock, without definite head injury. In certain instances, epileptic attacks of a typical Jacksonian type, with a regular march of the convulsive seizure were met with, but in other cases the diagnosis and indications for treatment were based on our experience of the result of the modern bullet wound on the skull, and a recognition of its far-reaching effects.

The treatment of head injuries of modern warfare is a question which has already provoked a good deal of discussion among surgical authorities, and several papers have already appeared in England and France on this subject. Holmes and Sergeant recently published the result of their immense experience of the treatment of a very large number of head injuries at the Boulogne base, and Tissot of the Hôtel Dieu, also gave his clinical experiences and ideas on the treatment of these cases. The present view of the situation may be summed up from a surgical point of view, by saying that the experience of the last sixteen months has been to the effect that immediate and extensive operations are not followed by good results, and that any attempt to remove deep seated projectiles is unjustifiable. The main point to be arrived at is to limit sepsis as far as possible, to provide drainage and to avoid unnecessary operations. These views were applied chiefly to the more serious and extensive injuries of the skull and brain, but they apply with equal force, in my opinion, to the type of glancing injuries which forms the subject of this article. These wounds, when first seen, are usually very dirty and already infected; and it has been found from experience that many of the cases, when trephined immediately, although apparently doing well at first, have subsequently developed a fatal septic meningitis. It has been my experience to see this happen in the case of several patients who had been operated on in France, and had been transferred to England apparently doing well, only to die of meningitis within a week or two of their transfer. I have discussed this question with several surgeons, who have had the opportunity of following cases of this kind from the time of the original injury. It is my firm belief that they are best treated in the first instance as simple scalp wounds, *i.e.*, thoroughly cleaned, shaved, washed with mild antiseptics and dressed with dry, sterile gauze. In almost every instance a certain amount of sepsis will follow in these war wounds of the scalp, unless they are dressed very early; but, frequently, this is quite mild, and in three or four weeks, when the wounds are often quite healed, the question of further treatment and the advisability of operative measures can be safely considered. In some cases the wounds may not heal completely, and it may be necessary, on account of persistent headache or other symptoms to operate in the presence of an infection. In the vast majority of cases, however, a much better result can be obtained by conservative treatment at first, followed by operative measures through a clean scalp, uncomplicated by a septic process, and without the dread of a meningitic infection, which recent experience has shown to occur not infrequently.

In operating on these cases, I have followed the plan of turning down a flap of moderate size in every case. I never enlarge the original wound caused by the bullet. In this way a good view of a large area of the skull is obtained, and the possible danger of stirring up any latent infection, which may be lurking in the recently healed scar, is avoided. The experience of this war work has shown us that the opening up of old scars is very liable to be followed by a recrudescence of a latent infection, and it is certainly preferable to excise the scar by an elliptical incision, rather than to cut into it. The ordinary flap operation obviates this necessity. The outer table having been exposed, some slight dent or grooving will generally be found under the site of the scalp wound. It is over this area that the trephine is applied. The trephining itself must be done with great care, as it is frequently found that the underlying inner table is broken up into fragments, and the *dura* liable to damage and tearing. In many cases it has been found necessary to remove two circles of bone and break away the bridge between, in order to get at the damaged inner table in its whole extent. In other cases the operation has been completed by removal of bone with Hoffmann's forceps or a cranial burr. In one case an epidural hæmorrhage was found, and in many instances the *dura mater* has been found intact, though bearing signs of scarring, evidently pointing to its having been injured and opened by the original trauma. In a few cases, large pieces of depressed inner table have been found perforating the *dura*, and in two instances detached pieces of bone were removed from the underlying brain, in which they were embedded. My experience of this type of head injury leads me to believe that in the majority of cases the *dura mater* is injured to some extent at the time. This fact alone is sufficient to lead one to the previously expressed opinion as to the advisability of conservative treatment at the outset. An operation undertaken at this time, in the presence of a septic scalp wound, must necessarily be accompanied by considerable risk of infecting the sub-dural space, and the not infrequent occurrence of this fatal complication has altered the views of surgeons on this question considerably. "Trephining in the trenches," as one speaker facetiously expressed it at a recent meeting, frequently leads to disaster.

I should like to conclude by giving the clinical records of a few of the various cases on which I have operated, illustrating the different conditions which have been met with. The first two cases de-

scribed are typical of quite 50% of this group of injuries.

**Cases.**

Case I.—Private S., A.I.F., æt. 21, was wounded at Anzac on August 7, 1915, and transferred to Malta, and afterwards to the Epsom War Hospital, where he was admitted on November 12. The bullet had struck him on the right side of the head, slightly behind the motor arm area. On admission, the wound was quite healed. He stated that he had been unconscious for a few minutes only, and, on recovery, he had suffered from severe headache and slight weakness, and awkwardness of his left hand. He complained at the time of admission of frequent headaches, but was otherwise quite well. Palpation over the scar revealed no depression or irregularity of the bone. There was a trace of weakness in the left hand, but no alteration of reflexes; no optic neuritis. His mental condition was good, but he lacked interest in his surroundings. This he attributed to his headache, which was severe at times.

November 27.—A flap was turned down over scar area. A slight dent was noted in the outer table. A one inch trephine circle was removed, when a piece of the inner table, about the size of sixpence, was found quite detached, and adherent to the *dura*. The latter membrane, however, was quite intact.

December 17.—Patient quite free from headache, and mentally alert.

Case II.—Private S., æt. 20, A.I.F., was wounded at Anzac on August 22, 1915, was transferred to Lemnos, and admitted to Epsom War Hospital on September 18, 1915. He was struck on the left side of the head, in the region of the motor arm area, was unconscious for half an hour, and, on recovery, noted slight weakness of the right arm. He had severe headache. On admission, there was practically nothing to be detected beyond the well-healed scar over the left strip, slightly tender on palpation, but giving no indication of any bony injury. There was possibly some weakness of the right arm. The reflexes were unaltered. No optic neuritis was detected. The boy complained continually of severe headache, and was mentally very dull.

November 1.—A flap was turned down over the scar, and, except that the latter was slightly adherent to the skull, nothing abnormal could be detected externally. On trephining, the inner table was found to be extensively broken up into small pieces, several being adherent to the *dura mater*. The trephine opening was slightly enlarged, and all the broken inner table removed.

November 28, 1915.—The patient was quite free from headache, and was comfortable.

These two cases serve to illustrate very well the marked damage to the inner table, associated with a practically intact outer table.

Case III.—Sergeant P., A.I.F., æt. 21, was wounded at Anzac landing on April 25, 1915. The bullet struck him over the mid-motor area, on the right side. He was unconscious for an hour, and, on recovery, found his left arm quite helpless, but was able to walk to the beach with difficulty. On being removed to the hospital ship, he again became unconscious, and remained in this condition for two days. He was transferred to Alexandria, and then to the Australian Hospital at Harefield, England, where he was admitted early in July, 1915. On examination there, there was found a completely healed scalp wound over the right motor area, definite weakness of the left arm, slightly increased left reflexes. Babinski's phenomenon was absent. He complained of frequent headaches. Mentally he was dull; his memory was indifferent. Soon after admission he had a typical Jacksonian fit, beginning in the left hand, becoming general, and being followed by great weakness of the left upper extremity. A flap was turned down over the scar area, and a definite groove was then seen on the outer table of the skull. On trephining, a large, jagged protrusion of the inner table was found, the pointed extremity of which had perforated the *dura mater*. The hole in the *dura* was closed with two fine catgut sutures. Six weeks later his condition was very good. The headaches were much less severe, the weakness of the left arm less marked, and mental condition much improved.

Case IV.—Private M., A.I.F., æt. 23, was wounded on May 10, 1915, at Anzac. A bullet had struck him over the right motor area. He was unconscious for an hour, and, on recovery, was unable to move his left arm; his left leg was weak, but he could walk. He was transferred to Alexandria, and afterwards to Harefield. On admission in July his wound was quite healed. He complained of headache, and gave a history of three fits, beginning in his left hand. There was definite weakness of the left arm, with increased tendon phenomena, no optic neuritis. A flap was turned down over the scar, and, as in case No. III., a slight groove in the outer table was detected. On trephining, a very similar condition was found. A large, wing-like process of inner table had been driven inwards, and the point of the process had perforated the *dura mater*. Some weeks later this patient reported himself to be very well. He was nearly free from headaches, and his left arm had improved greatly. There had been no recurrence of the fits.

Cases III. and IV. are excellent examples of that type of injury, where a very slight grooving of the outer table is associated with great and extensive damage to the inner table, wounding of the *dura mater*, and consequent cortical irritation and Jacksonian fits. I have lately heard from both these patients, and they have continued to improve.

Case V.—Sergeant F., æt. 19, A.I.F., was wounded on May 2, 1915, at Anzac. He had been struck by a bullet over the left side of the head, in the region of the fore-motor area. He was unconscious for five days, and, on recovery, suffered from complete hemiplegia, which cleared up after two weeks, except for some weakness of the right arm. He was admitted to Harefield at the end of June. There was a healed scalp wound over the fore part of the motor area, and, under this, a definite slight depression could be felt. Slight weakness of the right arm and almost complete motor aphasia were present. The right reflexes were increased, but Babinski's

sign was not elicited. There was no optic neuritis. He complained of severe headache at times.

On July 29, 1915, a flap was turned down, and a marked dent about the size of a threepenny piece found in the outer table. On trephining, the inner table was found broken up; one piece of bone had perforated the *dura*. On following up this track, an abscess containing about two drachms of pus, and enclosing a small piece of the inner table, was opened. The cavity was drained through a stab incision in the flap, which was sewn up completely. The boy did very well indeed. The abscess cleared up rapidly. In four weeks' time his speech had improved greatly, and the weakness of his arm was almost gone. No headache was complained of. He left for Australia in October, and was then rapidly improving in speaking and general condition.

These cases, and the one which follows, are good examples of the type in which severe injury to the underlying brain is found, with only the slightest external manifestations. Both patients were walking about, complaining only of headache; of course, a neurological examination in both cases made it quite clear that some serious trouble existed. In both cases the results were very gratifying.

Case VI.—Private K., A.I.F, æt 26 years, was wounded on May 25, 1915. He was struck over the left motor area. He was unconscious for half an hour, and, on recovery, there was loss of power in the right arm and weakness of the right leg. His wound healed up in five weeks, and he was admitted to Harefield early in August, 1915. He then complained of severe headache, defective memory, and giddiness, and gave a history of three epileptic fits (not Jacksonian). There was still definite weakness of the right arm, with increased reflexes on the right side, and rather delayed speech. No optic neuritis was seen. His wound was quite healed, and some depression on the outer table could be felt.

August 27.—A flap was turned down, and a slight depression of the outer table noted. On trephining, considerable splintering of the inner table and tearing of the *dura mater* were found. One piece of detached bone was found and removed from the underlying cortex, where it was deeply embedded. The trephine wound had to be enlarged considerably, to permit all the fragments to be removed. No abscess was present in this case.

Four weeks later this patient was much better. He still had some headache, but much less severe. His right hand was stronger, his memory better, and speech much brisker. He left for Australia in October.

Case VII.—Private T., æt. 21, 2nd London S., was wounded at Loos on September 26, 1915, and admitted to the War Hospital at Epsom on October 12, 1915. The bullet had struck him over the left parietal area, and he was unconscious for a few minutes. On recovery, he suffered from very severe headache. He was detained at a hospital in France for two weeks, during which time he complained of some numbness of the right limbs, without weakness, and also of difficulty in reading. During his first week's stay at Epsom his wound healed, but the headache continued to be severe, and he complained that his power of reading was still very deficient, in that the words only conveyed an imperfect meaning to him. No alteration of the reflexes were discovered. There was no optic neuritis or hemianopsia. On October 29 a flap was turned down over the wound. No change being found on the outer table, a circle of bone was removed, and the inner table was found uninjured, but an extensive epidural hæmorrhage was present. The collection of old blood clot was removed. The *dura mater* itself, being intact, was not opened.

In this case the ring of bone was replaced, and the man did excellently. He was up and about, free from all headache, and able to read well in two weeks' time. In this case an extensive hæmorrhage was evidently caused by the explosive force of the bullet acting through the skull, without injuring the overlying bone. Presumably it came from the rupture of one of the small posterior meningeal branches. Up to this date (December 26), this patient is in splendid condition. It is the only instance in my series of an epidural hæmorrhage without bony injury.

In the next and last case, I wish to report an instance of bullet wound of the head, in which neither bony nor meningeal injury could be demonstrated, and yet in which definite evidences of upper neurone disturbance could be demonstrated clinically.

Case VIII.—Private M., æt. 25, A.I.F., was wounded at Anzac on May 25, 1915. The bullet had struck him over the right side of the head, over the motor area. He was unconscious for two days, coming to himself on a hospital ship bound for Malta. He was in hospital in Malta for four weeks. On regaining consciousness, he suffered from partial left hemiplegia, very severe headache and difficulty with his vision. On admission to Harefield hospital in July, the wound had healed, but he was prostrated with the most severe attacks of headache. There was slight weakness of the left limbs, slightly increased left tendon phenomena, definite left homonymous hemianopsia (rough method), but no optic neuritis. A flap was turned down and a circle of bone removed in the ordinary way, but nothing was discovered. The *dura mater* was then opened very carefully, to see if there might be a subdural hæmorrhage, but nothing beyond a marked cortical hyperæmia was detected. The *dura* was sewn up carefully, and the circle of bone was not replaced. In this case a definite improvement followed the trephining, the headache being markedly relieved, up to the time when the patient was seen last. I believe this to be one of those cases, referred to in the earlier part of this paper, as due to nerve shock, where the explosive force of the bullet is conveyed through the bone and *dura mater* without injury to either of these structures, to exert its harmful influence on the underlying cortex.

I do not propose to quote any more of these cases in detail, as the majority of the twenty-nine would conform in many respects with one of the eight cases

quoted. A study of these various cases appear to me to establish the following conclusions.

**Conclusions.**

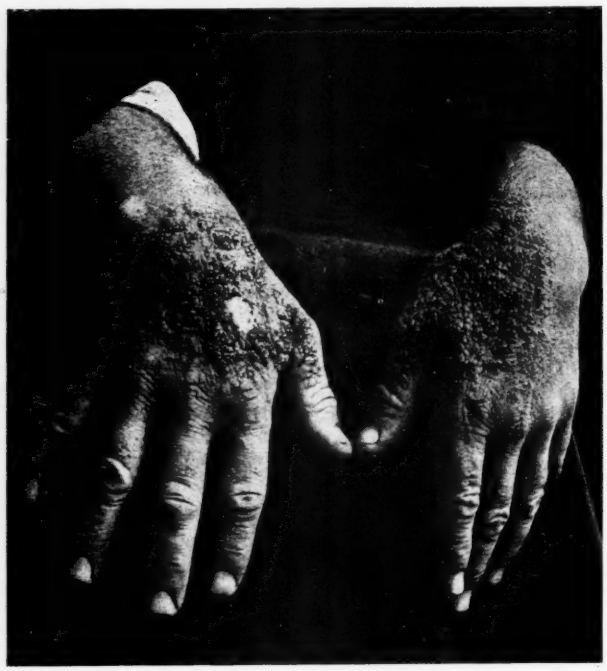
(1) Glancing bullet wounds of the skull are extremely common in this war.

(2) Every scalp wound caused by a modern bullet, no matter how mild it may appear to be, must be looked on with suspicion and carefully watched.

(3) That very slight injury to the outer table is frequently associated with extensive damage to the inner table.

(4) That every case of scalp wound with persistent headache or the slightest neurological sign should be explored.

(5) That this type of injury is best treated by conservative measures at first, and that, unless distinctly contraindicated, operation should not be attempted till the scalp wound has healed.



## Reports of Cases.

### COLLOID DEGENERATION OF THE SKIN.

By **Langloh Johnston, M.B., Ch.M., (Syd.),**
*Honorary Physician for Diseases of the Skin, St. Vincent's Hospital, Honorary Assistant Physician for Diseases of the Skin, Sydney Hospital;*
and
**Norman Paul, M.B., Ch.M. (Syd.),**
*Honorary Assistant Physician for Diseases of the Skin, Sydney Hospital.*

Colloid degeneration, or colloid milium, is a rare disease of the skin, of which there are but few authentic recorded cases. However, within the space of a month, two patients with this condition presented themselves at the Skin Department of the Sydney Hospital. In one, the dorsal surfaces of the hands alone were affected, whilst the other, G.W., æt. 37, a butter carter, had a symmetrical eruption affecting more than half of the dorsal surfaces of the hands, as well as the proximal digits of the thumbs. This extended to, or slightly beyond, the wrist, whilst some few lesions are now appearing on the forearms. It is on the dorsal surfaces of the hands that the eruption is most marked, and of greatest intensity. The nape of the neck is similarly affected, and extends in the form of a band, above the collar, as far forward as lobes of the ears. There is an eruption on the face, which appears to be of more recent origin, and not so highly developed as that on the hands and neck. It affects the malar regions of the face, and extends across the bridge of the nose, resembling in this distribution the bat wing type of *lupus erythematosus*. Here there is a distinctly yellow appearance, which is also to be observed in the other situations, but not to such a pronounced degree. The eruption first started seven years ago on the thumbs, and has been slow and insidious in its progress. It consists of small papules, some of which are discrete, whilst others are aggregated, but the individual character of these can readily be distinguished. The smallest of the lesions appear to be situated in the cutis, and are slightly, if at all, elevated. This constitutes the character of the eruption on the hands and neck, but the eruption on the face has a more vesicular appearance. The majority of the papules are millet-seed-sized, some being larger, whilst a few are hemp-seed-sized. The individual papules appear waxy in consistence, with a clearer, translucent centre, giving a vesicular character. They are, however, firm to the touch, and on pricking with a needle, only a drop of blood exudes. When the patient perspires freely, there is some itching, otherwise there are no subjective symptoms. The patient is a robust man, exposed to the weather, and has always enjoyed good health. A piece of skin was removed from the dorsum of the hand for microscopical examination. Sections showed in the corium, corresponding to the elevations seen macroscopically, round areas, containing a homogeneous, structureless material, which proved on suitable staining to consist of colloid.

With picro-carmine these masses stain yellow, whilst the connective tissue fibres immediately surrounding also show partial degeneration and take the yellow stain; the rest of the connective tissue fibres have a pinkish colour. The epidermis above these colloid masses is thinned, and in some cases ruptured, probably during preparation of the section, thus allowing the colloid contents to escape, either partially or almost entirely. There is no epithelium or endothelium surrounding the colloid masses, or lining the cavities from which the degenerative material has been expressed.

Microphotograph of Section. *a*. Epidermis ruptured, and contents escaped.

The papillæ are pressed out above, but are still in evidence between the colloid masses. Sweat glands, sebaceous

glands, and hair follicles remain unaffected. The observations of Balzer and others have shown that colloid is formed by a degeneration of the collagen and elastic fibres of the corium. According to the Unna, collastin is produced from this degeneration, and by homogenization and swelling colloid is formed, whilst collastin, which has the reaction of elastin, is in evidence around the colloid masses. Unna also asserts that collacin in large quantities is formed in parts of the corium, independent of the colloid changes, from a combination of the elacin drops, and granules, and collagen.

# Reviews.

## INFECTION AND PROTECTION.

Dr. John A. Kolmer has set himself a very large task. He has started out to compose a practical text-book on "Infection, Immunity and Specific Therapy,"[1] for the purpose of giving medical students and practitioners a connected and concise account of the ways in which the body may become infected, or the means by which the organism protects itself against infection, or strives to overcome infection after it has taken place, and of the manner in which this knowledge may be employed in the diagnosis, prevention and treatment of disease. Incidentally, he has endeavoured to present to the laboratory worker a reliable immunological guide, and to prepare a laboratory course for students and practitioners. In the past these subjects have been dealt with in an inadequate manner in text-books on bacteriology, and in monographs. Some publications have contained the general principles of experimental medicine, and a few have covered the whole field. The task is rendered especially difficult as the knowledge in this branch of science is extending rapidly, and every author must labour under a disadvantage, since fresh facts are brought to light before any book of reasonable dimensions can be finished. The rapid increase in the number of facts and theories detracts from the essential value of any text-book, because teaching should be based on facts, and not on mere assumption.

The author has applied himself with extraordinary assiduity and diligence to his task, and has spared neither himself nor his readers in his presentation of the vast subject of experimental preventive medicine. The first part of the book contains a full and quite reliable account of the general technique employed. The student will find the diagrams and illustrations of much use in the performance of the various laboratory manipulations. Indeed, the author has been almost profligate in this respect, and has supplied a superabundance of black and white, as well as coloured illustrations, which, although of value, must increase the cost of production out of proportion to the gain achieved.

In the second part, the author discusses infection and the mechanism of defence. He adopts an arbitrary classification of bacteria into saprophytes and parasites, and is satisfied to register the entry of the latter into the organism under the heading of invasion, leaving the subjects of the mechanism of the production of disease and the manifestation of symptoms to be handled somewhat imperfectly together with the immunity processes. Virulence is dealt with largely on the basis of Welsh's hypothesis, a hypothesis which has more opponents than supporters. Throughout the portion of the work in which the products of bacterial activity are dealt with, reliance is placed on the work of Victor Vaughan. The fundamental chemico-physical principles of protein cleavage by sodium hydrate in alcohol are too inexact and nebulous to command general acceptance. In contrast to this, the ingenious side-chain theory of Ehrlich, although no doubt wanting in many details, satisfies the majority of the requirements, and still stands pre-eminent as a working hypothesis.

The author discusses the structure of toxin, according to Ehrlich and to those who have followed this line of study, and then essays to analyse its nature. He defines toxins as "synthetic products of bacterial activity," and contrasts them with ptomaines, which he regards as "the cleavage products from the medium upon which the bacteria have been grown." Experimental data, throwing light on the nature of toxin, are lacking. Some day we may know what a bacterial toxin is, and when this knowledge is gained, the whole teaching will have to be recast.

If his treatment of bacterial toxins is open to criticism, in view of the paucity of facts, his handling of endotoxins is still more speculative. But since his object is to present his subject for teaching purposes, it is necessary to make the best use of available facts. He has accumulated all the knowledge that has occupied the attention of biologists and bio-chemists during the past ten years. The literature up to 1913 has been ransacked with laudable thoroughness in the preparation of the descriptions of toxins, aggressins and ptomaines.

Part III. is a treatise on immunity, and, consequently, consists in part of facts and in part of deductions. It is well written, and is typical of the present-day teaching. Perhaps the pendulum has swung too far over on the side of phagocytosis since the days when Metchnikoff's ideas were regarded as of limited theoretical interest. The genius of Almroth Wright has lent a picturesqueness to the rôle of the leucocyte as a protective agent, and this may have disturbed our sense of proportion. Were other agents controlled in a similar pictorial manner, it is possible that the views held might have to be modified. The author probably shares this view, for he refers from time to time to the defects and limitations of the opsonic doctrine. He does not hesitate to say that the estimation of the opsonic index has fallen into disuse.

He hazards a great deal in his chapter on ferments and antiferments. He assumes that ferments, like toxins, are metabolic products of living cells. This may be so, but the available evidence would rather tend to show that ferment action is due to a particular form of molecular arrangement of globulin. On the other hand, no essential association with globulin exists in the case of toxin. While the theoretical considerations are open to criticism, the descriptions of the practical application of knowledge gained in this field are excellent.

From antigen and ferment he leads his reader to antibody and antiferment, and thence to the clinical tests. No better account of these tests has been published. A note is attached to each, indicating its clinical significance. These estimations appear to have been arrived at by others, but clinicians will find them reliable in the main.

A few words must be devoted to his chapters on tuberculin. This subject is divided into two branches, the diagnostic and the therapeutic. The author, like the vast majority of biologists, assumes the specificity of tuberculin. Sooner or later the subject must be investigated scientifically. The statement is made that a positive tuberculin reaction means that the individual reacting has a tubercular infection. Even if this be true, it is not evidence of the biological specificity of the test, and there would seem to be indications that the statement has not universal application. An identical reaction can be obtained with non-specific material. In this respect it would appear as if there were an analogy between the specificity of the tuberculin test and that of the Wassermann test. The future may reveal a chemical rather than a biological specificity.

Anaphylaxis is regarded from the Vaughan perspective. Since no explanation of the phenomena is satisfactory, the views championed by the author may be put forward with as much justification as those of Richet, Friedberger or others. It is doubtful, however, whether Vaughan's views are satisfactory from a teaching point of view.

It will thus be seen that Dr. Kolmer has faced his difficulties with pluck, skill and perseverance. He has compiled a text-book of great importance and high merit. That it will be widely used is certain, and, for the time, it must occupy the foremost place among books on infection and immunity.

[1] A Practical Text-Book on Infection, Immunity and Specific Therapy, with Special Reference to Immunologic Technic, by John A. Kolmer, M.D., D.P.H., with an Introduction by Allen J. Smith, M.D., Sc.D., LL.D., 1915. Philadelphia and London: W. B. Saunders Company; Roy. 8vo., pp. 899, with 143 original illustrations, 43 in colours, by Erwin F. Faber. Price, 25s 6d.

# Public Health.

## THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending March 25, 1916:—

| | Metropolitan Combined Districts. Cs. | Dths. | Hunter River Combined Districts. Cs. | Dths. | Remainder of State. Cs. | Dths. | Total. Cs. | Dths. |
|---|---|---|---|---|---|---|---|---|
| Enteric Fever | 25 | 5 | 3 | 0 | 40 | 2 | 68 | 7 |
| Scarlet Fever | 55 | 0 | 4 | 0 | 88 | 0 | 147 | 0 |
| Diphtheria | 91 | 6 | 11 | 0 | 108 | 3 | 210 | 9 |
| C'bro-Sp'l Menin. | 1 | 0 | 0 | 0 | 1 | 0 | 2 | 0 |
| Infantile Paralysis | 13 | 0 | 0 | 0 | 9 | 0 | 22 | 0 |
| Pul. Tuberculosis | 32 | 8 | 0 | 2 | 0 | 0 | 32 | 10 |

## THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending March 26, 1916:—

| | Metropolitan. Cs. | Dths. | Rest of State. Cs. | Dths. | Total. Cs. | Dths. |
|---|---|---|---|---|---|---|
| Diphtheria | 73 | 2 | 44 | 2 | 117 | 4 |
| Scarlet Fever | 12 | 0 | 19 | 0 | 31 | 0 |
| Enteric Fever | 7 | 0 | 11 | 0 | 18 | 0 |
| Pulmonary Tuberculosis | 22 | 9 | 15 | 5 | 37 | 14 |

The following is the number of cerebro-spinal meningitis cases notified to the Board during the week ending March 26, 1916:—

| | Metropolitan Area. Cases. | Rural Districts. Cases. | Total Cases. |
|---|---|---|---|
| Military | — | — | 2 |
| Civilian | 4 | 2 | 6 |

## INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending March 25, 1916:—

| Disease. | No. of Cases. |
|---|---|
| Scarlet Fever | 4 |
| Diphtheria | 37 |
| Infantile Paralysis | 3 |
| Enteric Fever | 44 |
| Erysipelas | 1 |
| Pulmonary Tuberculosis | 5 |
| Malaria | 2 |
| Varicella | 3 |
| Puerperal Fever | 1 |
| Total | 100 |

## INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending March 18, 1916:—

| | Diphtheria. Cases. | Enteric Fever. Cases. | Scarlet Fever. Cases. | Pulmonary Tuberculosis. Cases. | Erysipelas. Cases. |
|---|---|---|---|---|---|
| Fremantle | 2 | — | — | — | — |
| Cottesloe | — | 3 | — | — | — |
| Claremont | 1 | 1 | — | — | — |
| Subiaco | — | 2 | 1 | — | — |
| Perth | 10 | 4 | — | 1 | — |
| Midland Junction | — | — | — | — | 1 |
| Belmont | — | — | — | 1 | — |
| Queen's Park | 1 | — | — | — | — |
| Kalgoorlie | 1 | — | — | — | — |
| Boulder | 2 | 1 | — | — | — |
| Nangeenan | — | 1 | — | — | — |
| Osborne Park | 1 | 1 | — | — | — |
| Kellerberrin | 1 | — | — | — | — |
| Westonia | — | 2 | — | — | — |
| Kurrawang | — | 1 | — | — | — |
| Norseman | 2 | — | — | — | — |
| Wickepin | — | — | — | 1 | — |
| Brownhill | — | — | — | 1 | — |
| Laveton | — | — | — | 1 | — |
| York | — | — | — | 2 | — |
| Southern Cross | — | — | — | — | 1 |

## SMALL-POX IN NEW SOUTH WALES.

During the week ending April 2, 1916, two cases of small-pox were reported from the Newcastle district.

## WELCOME TO THE HON. DR. BEESTON, C.M.G., M.L.C.

In the Legislative Council of New South Wales on March 21, 1916, the Deputy President offered a few words of welcome to the very distinguished member of the House who had been honoured by their King, and who had rendered such distinguished service to their soldiers at the front. He conveyed to Dr. Beeston their warm appreciation of the high distinction conferred upon him by his Majesty the King, and the magnificent way in which his services were acknowledged by the people of Newcastle.

The Hon. J. D. Fitzgerald associated himself with the remarks made by the Deputy President. He thought it a splendid thing that men with the attainments of the honourable member, Dr. Beeston, entered into the struggle, and did what they could to carry this war to a successful issue.

The Hon. Sir Joseph Carruthers joined in the welcome which had been extended to Dr. Beeston. Amongst innumerable heroes produced in this war there were none who had a greater claim to the admiration of the public than those who had worn the Red Cross. The hon. member was a non-combatant, yet he went to the front with his regiment, and shared the dangers with men who were fighting. He had rendered splendid service to the Empire. Not that he belittled those who simply did their work in the Base Hospitals, because they were witnesses of scenes which must have touched the inmost fibres of their nature. They were proud of the honourable member, and glad to welcome him home again.

The Hon. J. Garland said they were all proud when the honourable member volunteered to take part in this great struggle. They now knew that he had fulfilled their utmost expectations. Dr. Beeston had done his duty gallantly and well, and their King had recognised the magnificent services rendered by him.

The Hon. Dr. Beeston, in reply, expressed his thanks for the kind things which had been said in recognition of his humble efforts among the soldiers at the front. He did simply what was his duty, but it had fortunately happened that he was placed in such a position that he was able to render some service to the wounded. The experience which the medical officers went through at Anzac had been one which he thought would never be forgotten by any of them. It had been one too upon which he thought all of them could look back with pride from the fact that once they set their hands to the ploughs they went right through with the job.

The following names have been included in the 158th, 159th, and 160th official lists of casualties, etc., issued on March 30 and 31, and April 3, 1916:—Captain W. M. A. Fletcher, 2nd Australian General Hospital (previously reported seriously ill), is now convalescent; Captain W. G. Brown, ill; Captain S. J. Cantor, seriously ill; and Captain A. C. Smith, injured.

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We regret to record the death of Mr. J. C. Ludowici, which took place at Longueville, Sydney, on April 2, 1916. Mr. Ludowici was the father of Dr. E. Ludowici, of Sydney, to whom we offer our sincere condolence.

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A curious case has been reported in the Adelaide daily press. Dr. J. A. G. Hamilton, of Glenelg, was being driven in his motor car by his daughter at a high speed, when the police considered that it was their duty to interfere. Miss Hamilton was therefore summoned on the charge of exceeding the speed limit. The defence put up was that a medical man should be allowed to proceed to a patient as rapidly as possible. The magistrates, however, determined that doctors were not exempt from the law, but, in view of the nature of the defence, a conviction alone was entered, and no fine was inflicted.

The Medical Journal of Australia.

SATURDAY, APRIL 8, 1916.

## The Alcohol Question.

There is no more difficult problem in the world than the alcohol problem. From a medical point of view, every one with knowledge and experience recognizes that alcohol taken in excess is the cause of countless degenerations and directly or indirectly of innumerable pathological changes. Moreover, it is generally accepted that alcohol is not only a cause of disease, but a habitual abuse of it is a manifestation of an abnormal state. The alcohol question, from its medical aspect therefore, involves two distinct problems, one of which would be relatively simple were it not inseparably connected with the other. The withholding of alcohol from the drinker, if complete and permanent, would remove the immediate and remote effects of the poison, and would lessen to a marked degree the incidence of venereal infections, as well as place the individual in a far better position to resist the effects of other infections. But the mere removal of alcohol would in all probability not alter the inherent condition on which alcoholism is based, at all events in so far as the first generation is concerned.

From the social aspect, the problem is complicated in other ways. At the present time, the community is more concerned about the efficiency of our soldiers than about the physical fitness of the present and the next generations. It is of paramount importance that the men who are fighting for the continued supremacy and integrity of the Empire should be in the best condition to meet the severe trials of trench life and the other dangers connected with modern warfare. The honour of His Majesty's uniform must remain unsullied, and an army of drunkards cannot be trusted to uphold the dignity and prestige of British arms. Universal sobriety in the army could only be obtained by a universal prohibition of the sale of alcoholic beverages. This ideal, however, is practically impossible to achieve, and any proposition put forward at present with this end in view would meet with strenuous opposition. In Western Australia, the hours for the public sale of intoxicating drinks were limited by legislative means some months ago. The latest movement in this direction has taken place in Tasmania, where the people, by the dangerous instrument, the referendum, have decided on the closing of all licensed premises at 6 p.m. It is outside the province of a medical journal to consider the claims of those who have what is known as vested interests; but the community has to take this side of the question into account, and to consider whether undue hardships are being inflicted on a considerable section of the population. But it may be claimed that no considerations of this kind should be allowed to interfere with the welfare of the community as a whole, and if a section of the population gains its livelihood at the cost of health, that livelihood must be sacrificed.

The early closing of premises licensed for the sale of alcoholic beverages, provided that sly grog selling is checked and that the military authority prevents soldiers in camp from carrying drink back with them on their return from day leave, will no doubt bring about a material diminution of abuse among the men in khaki. But would not a better result be obtained if no publican were allowed to serve a man wearing His Majesty's uniform? If the movement at present is being directed to the eradication of drunkenness among soldiers, it would seem as if the less efficient remedy were being selected. For the rest of the community, the solution appears to be extremely crude. The constant preaching of the doctor on the disastrous effects of excessive indulgence in alcoholic beverages has been far more effective than legislative measures in reducing drunkenness, but it must be remembered and emphasized that excess is a very elastic term, and a very little may be too much in a given individual.

### COLLOID DEGENERATION OF THE SKIN.

By a curious coincidence, Drs. Langloh Johnston and Norman Paul have been placed in the position to observe two cases of a very rare cutaneous condition. The account which they publish in the

present issue will attract the attention of dermatologists on account of the concise and admirable presentation of one case, and also on account of the extremely typical appearances. Colloid degeneration of the skin was first described by Wagner in the year 1866, under the name of colloid milium. It would seem that the second case observed was communicated by Besnier, in 1879. In the year 1886, Liveing described three cases in the *British Medical Journal*. Other cases have been observed by Feulard, Reboul, Philippson and others. The full number of recorded cases, however, remains small. An excellent review of the subject was published by Philippson, in 1891. This author attempted to prove that colloid milium and hydradenoma were identical pathological processes, but the closer histological study undertaken by Balzer and Reboul have revealed that this view is erroneous. In regard to the pathology of the affection, our knowledge is largely derived from the observations of Balzer. Wagner thought that the affection was localized in the sebaceous glands, but Balzer was able to show that the degeneration started as an infiltration of the endothelium of the vessels in the upper layers of the corium. The observations made in Unna's clinic are recited in Drs. Johnston and Paul's paper. As far as we are aware, the exact chemistry of the colloidal contents of the corium has not been made out, and it does not appear as if the pathology has been rendered more clear by these observations and suggestions. The affection is extremely obstinate, and apparently incurable by ordinary means, although spontaneous cure is stated to have occurred. Our authors may have further opportunities of studying their cases and of contributing to our knowledge of this rare and obscure affection.

## STATISTICS AND DISEASE.

In another column we publish a preliminary report of the Committee appointed by the Minister for Trade and Customs to enquire into the causes of death and invalidity in the Commonwealth (see *The Medical Journal of Australia*, January 29, 1916, p. 101). This report has assumed the character of a skeleton programme of work, rather than that of a preliminary investigation, but is none the less interesting on this account. Readers will be struck by the very wide extent of the scope and by the somewhat unusual problems which have been included. In all investigations into the causes of death and invalidity undertaken by those accustomed to regard health and disease from the point of view of the administration of laws aiming at an improved public health, tuberculosis, cancer, infective diseases, industrial diseases, diseases peculiar to infants and pathological conditions affecting women in the puerperal state necessarily find a prominent place. On the other hand, we note with satisfaction that the subject of disease connected with changes in the heart and arterial system is to be investigated. In spite of the obvious fact that this group of diseases contributes more largely than any other to disablement and to death, no serious attempt has yet been made to deal with them from the aspect of preventive medicine. Traced to their final causes, it has been found that many of the pathological conditions of the cardio-vascular system depend on preventible changes, while others are associated with noxes, the ravages of which can be limited. It is also eminently gratifying that alcoholism and venereal disease should be included among the causes of invalidity to be studied. It may therefore be said that the programme of work of the Committee promises well, and we look forward to the next stage for much valuable information, which may be found of importance in the formulation of preventive measures, to the benefit of the Commonwealth and the world.

## CARDIOPHONOGRAPHY.

Methods of recording objectively the sounds of the human heart have existed for more than twenty years, but no fruitful results, either for medical practice or for the study of the action of the heart in general, have been accumulated until quite recently. This was due to the complicated nature of the methods used and the considerable technical skill requisite for their application. Great difficulty was also found in determining the exact phase in the cardiac cycle in which the sound or murmur occurred. This difficulty was insurmountable when the action of the heart was markedly irregular. The introduction of the string galvanometer, which made it possible to examine with accuracy the changes in electrical potential during the heart-beat, has provided a suitable record for synchrony with the cardiac sounds. The simultaneous registration of the heart's sounds, with the electrical changes on the same photographic plate used first by Lucien Bull at the Marey Institute in Paris, has been applied with great success by Lewis, in London, and Batteard, in Leyden. The exact moments at which a sound starts and ends can be ascertained with an accuracy measured in thousandths of a second.

Cardiophonography deals with aerial vibrations, not with sensations of sound. The conception of a sound is a psychic judgement, based on the association of the sensations called into consciousness by the vibration of the tympanic membrane, with the memories of past sensations and with other impressions received at the same time. An engineer, amid the din of clashing machinery, selects the sounds of the human voice with little difficulty. He

separates the sensations of the voice from those of the clanging metal. The novice is bewildered by a multitude of sensations which he cannot analyse into separate recognizable sounds. The cardiophonogram makes no selection among the vibrations it records. The trained ear can appreciate the characters of the first and second sounds, even when they are confused by the presence of a murmur. It can likewise detect the peculiarities of a murmur without reference to the presence of the usual cardiac sounds. The physician is thus able to direct his attention to some of his sensations, and to neglect others in forming his mental concept of what he hears with his stethoscope.

The mental picture of the acoustics of the same heart-beat formed by two physicians may be quite different, owing to the emphasis laid on different parts of the sensations experienced. The cardiophonogram gives an unbiassed record of the vibrations. It emphasizes no part, and it neglects no part of the aerial waves. It may even record vibrations of too small amplitude to excite the human auditory mechanism. Its advantage lies in its accurate chronoscopy. In this respect it outdistances the human instrument, which is unfitted to deal with such accurate timing of events. Its principal disadvantage is dependent on the changes in pitch of the various phases of the cardiac sounds. The ear is adapted to detect rapid changes in pitch, and to separate these notes from one another. The graphic method records the differences in the rates of vibration, but it is no easy matter to detect these changes on the tracing, which gives no clear impression comparable with the change in pitch noted by the ear. The cardiophonogram must be regarded as complementary to the stethoscope, amplifying and correcting the information derived through the indispensable instrument of clinical medicine.

## ACIDOSIS.

Acetone, aceto-acetic acid and beta-oxybutyric acid are excreted together in the human urine. The presence of these bodies in diabetic urine has long attracted the notice of the physician. It is not known so widely that they are found in the urine in traces during health, and in considerable amount during starvation. It is believed by many that their excretion is due to the body exhibiting a state of acidosis, as it has been named by Naunyn. It was assumed by some that the excretion of these substances was conditioned by the faulty metabolism of carbohydrates. Investigations have, however, shown that these substances are usually derived from fats. Their excretion has been studied since biochemists have endeavoured to obtain information through them of the faulty metabolism of fats. The study of the metabolism of fats in healthy persons is beset with difficulties which have so far proved unsurmountable. All that has been ascertained with certainty is that, under normal circumstances, fats are oxidized to water and carbon dioxide.

Most investigators have obtained evidence that seems to show that these substances are derived entirely from fats, but Dakin has shown that certain amino-acids, which are present in the protein molecule, can yield on decomposition within the body aceto-acetic acid. A research[1] carried out recently at Glasgow by R. M. Lang has yielded some interesting results in regard to the acidosis produced by starvation. The administration of small amounts of carbohydrates greatly diminished the excretion of acetone in persons who have been starved. The administration of fats under similar circumstances increases the degree of acidosis. The clinical observation that the sudden complete withdrawal of carbohydrates from the diet of a diabetic determines the onset of acidosis, receives adequate explanation in the light of this observation, especially when it is remembered that the withdrawal of carbohydrates is usually accompanied by the administration of fats in large quantities. It is believed by many physicians that marked reduction in the amount of sugar and starches is preferable to their complete removal from the diet, and this opinion does not seem to be devoid of good foundation.

## NURSES AND DISPENSING.

There seems to be a misapprehension among the Hospital Trained Nurses that the attendance for a limited number of hours in the dispensary of the Royal Prince Alfred Hospital and of the Sydney Hospital (a certificate to such effect being issued to them by the hospital authorities) qualifies them to dispense doctors' prescriptions. Nothing can be further from the truth, and the Pharmacy Board desires to point out the risk they are running if the practice is not discontinued. The Pharmacy Board is the only body in the State of New South Wales entitled to examine, register, and issue certificates in regard to the dispensing of prescriptions. Any person who dispenses prescriptions without such qualification is punishable by a fine, the minimum being £5 and the maximum £50. The Board would be very reluctant to enforce this portion of the Act, and thereby make an example of someone who, in all probability, is quite unaware of the true position regarding dispensers, but feels that, if the practice is continued, it will be forced to put the machinery of the law into motion. The Board has, therefore, asked us to publish these facts as a warning to nurses and their employers.

## PROPOSED MEMORIAL TO THE LATE DR. T. S. HALL.

It is proposed to raise a fund amongst old students and friends of the late Dr. T. S. Hall to perpetuate his memory and to recognize the value of his work. Dr. Hall was closely associated with the Melbourne University during the past twenty-three years, and devoted much time to the work of the "Royal Society" and "Field Naturalists' Club of Victoria," and the Australasian Association for the Advancement of Science. He loved the furtherance of knowledge for its own sake, and was so wrapped up in his work that his pecuniary resources were always slender.

It is proposed—

(1) To devote a small sum to the erection of a tablet in the Biological Department of the Melbourne University.

(2) To use such portion of the fund as may be determined upon in the purchase of an endowment policy payable at a fixed date in favour of Dr. Hall's youngest son, now aged six; the money to be devoted to such purposes as may be deemed most suitable when the policy matures.

(3) To utilize the remainder, if any, of the fund in such other way as shall be decided upon by the committee for the benefit of Dr. Hall's family.

Dr. J. P. Wilson has consented to act as hon. treasurer, and subscriptions may be sent to him, to Mr. J. H. Maiden, Botanic Gardens, Sydney, or to Professor Baldwin Spencer, Melbourne University.

[1] *Biochemical Journal*, Vol. IX., p. 46, 1915.

# Abstracts from Current Medical Literature.

## MEDICINE.

### (131) Modes of Infection in Tuberculosis.

M. P. Ravenel discusses respiratory and digestive track infection in tuberculosis, with a view of ascertaining the most usual mode of entry of the tubercle bacillus into the human organism (*Journ. Amer. Med. Assoc.*, February 26, 1916). He points out that the work of Arnold and Cornet established the fact that respiratory infection was not accomplished by simple inhalation, but that the infective material found its way into the bronchial lymphatic glands. In turning to infection through the digestive tract, the author gives a short resumé of the observations made in this connexion from 1846 down to 1901, when Koch made his celebrated statement. Subsequent to that date, a large amount of work has been conducted with a view of ascertaining the frequency of bovine infection in man. According to Park, the infection was bovine in 76 out of 368 children between infancy and five years of age, in 46 out of 177 children between five and sixteen years of age, and in 15 out of 955 adults of sixteen and over. There appears to be some difference of opinion as to the frequency of primary tonsillar infection. The tonsil can be readily infected in laboratory animals, and Grober has expressed the opinion that infection through the tonsil is a most frequent origin of apical tuberculosis. A great deal of work has been done with a view of determining the age at which a tubercular infection occurs. Positive reactions by the intracutaneous method of application of tuberculin were found by von Pirquet in 5% of infants under one year of age, in 20% of children between one and two, in 35% of children between two and four, in 48% of children between four and seven, in 64% of children between seven and ten, and in 80% of children between ten and fourteen. According to Hamburger and Monti, 94% or 95% of children over eleven yield positive reactions. On the other hand, Overland only obtained 50% and Müller obtained 54% of positive results. The author has collected the available evidence dealing with infection in adult life. It appears that very few medical practitioners, nurses or other attendants in sanatoria or chest hospitals have contracted consumption. Goring has shown that the incidence among those connected with a tuberculosis hospital is practically identical with that among individuals of non-tubercular parents. On the other hand, marital infection is undoubted. In summing up, the author concludes that the infection in tuberculosis follows the respiratory tract, and that the alimentary tract is a frequent portal of entry of the tubercle bacillus. The bacillus is able to pass through intact mucous membrane of the alimentary tract without producing a lesion at the point of entry. He expresses the opinion that any campaign against tuberculosis which leaves out of consideration the protection of children against infection is likely to fail.

### (132) The Electrocardiograph.

J. A. Lindsay gives a clear account of the significance, as far as it has been ascertained, of electrocardiography (*Dublin Journ. of Medical Science*, February, 1916). He traces the discovery of the fact that the heart beat is accompanied by an electric discharge to Kölliker and Müller in 1858. Einthoven's instrument is a string galvonometer of sufficient delicacy to record these electrical discharges. Three leads are employed, *viz.*, right arm and left arm, right arm and left leg, and left arm and left leg. The strings have a resistance of from 5,000 to 10,000 ohms. Electrocardiography is based on the principles that electrically active muscle is relatively negative to inactive muscle, and that the direction which the excitation wave takes governs the form of the resulting curve. The excitation wave precedes the contraction wave by an extremely short interval. Both waves take their origin at the sino-auricular node, which has been termed the "pacemaker." Normally, the rate of transmission of the excitation wave is approximately 1,000 mm. per second. From the auricles it passes to the ventricles, through the bundle of His. In the normal electrocardiogram, five curves are detected, which are known by the letters P, Q, R, S, and T. P is auricular in origin. Following this curve there is a short period of quiescence, and a marked elevation above the line. The R wave follows immediately, and is ventricular in origin. A slight movement above the line between P and R is termed the Q wave. The significance of this wave is not understood. Similarly, a slight movement below the line following R is spoken as the S wave. This wave is of importance in the estimation of pathological conditions. The period of active contraction of the ventricular muscle is depicted by an elevation following the S wave, which is known as the T curve. P, R and T are present in all normal hearts. Q and S are often absent. The first sound of the heart begins about $^1/_{50}$ second after the R wave. The second sound is usually coincident with the end of the T curve, but may precede or follow the end of this curve by an interval of not more than $^1/_{50}$ of a second. The author proceeds to describe the characteristics of electrocardiograms in cases of heart-block, auricular fibrillation, auricular flutter, myocardial degeneration, extra systoles and hypertrophy of the ventricle. In heart-block the bundle of His is affected, and, consequently, there is a prolongation of the P-R interval. The interval is normally 0.18 second, but is not infrequently as long as ⅓ of a second in heart-block. In complete heart-block, the rhythm of the ventricle is independent of that of the auricle, and may be from 1: 2 to 1: 4. In auricular fibrillation, the auricles no longer contract, but their surfaces present irregular, tremulous flickering movements. It may arise in any form of failing heart, and in certain forms of myocardial degeneration. In the electrocardiogram, the deflection P has disappeared, and has been replaced by a series of wavy lines of low elevation. In auricular flutter the auricles contract at a rapid rate, and the ventricles beat with each second, third or fourth auricular contraction. The P wave is repeated several times before the ventricular phase begins. The author concludes by expressing diffidence in speaking of the interpretation of electrocardiograms.

### (133) Abnormality of the Heart in Infectious Diseases.

C. S. Chaplin has taken part in a symposium on heart disease, and deals with the condition of the heart in various infectious diseases (*Boston Med. and Surg. Journ.*, February 17, 1916). He analyses the subject from the point of view of three facts: (1) That the heart's action is modified by an increasing temperature, (2) that the heart reacts differently according to the toxins producing the fever, and, thirdly, that that the heart itself may be the seat of the condition. He insists that it is unwise to differentiate endocarditis, myocarditis and pericarditis sharply under all conditions. The febrile heart beats at an increased rate. Roughly speaking, there is an increase of from eight to ten beats, with a rise of temperature of 1° F. At first, the sounds are clear and distinct, but later some dilatation may occur. After prolonged fever, the sounds may become feeble and tricuspid, or mitral systolic murmurs may be heard. When the myocardium is involved in the process, changes in rhythm are noted, and ventricular systoles may drop out as a result of lesions of the auricular-ventricular bundle. The author deals with the physical signs of acute endocarditis, and points out that murmurs due to endocarditis are usually not recognized until some time after the subsidence of the fever, when sclerosis has set in. This is particularly true in the case of presystolic mitral murmurs, which are never recognizable during the acute condition, unless there is a narrowing of the orifice due to vegetations. In describing the signs and symptoms of pericarditis, he points out that some patients go about as usual for several weeks with a well-marked to and fro murmur, without suffering any inconvenience. The chief cardiac lesions in rheumatic fever are acute dilatation, endocarditis and pericarditis. Acute dilatation may be signalized by a slight rise in the pulse-rate by the cardiac impulse becoming diffuse and extending outside the nipple

line, and by the increase of the cardiac dulness to the left. The first sound of the reflex may become short, and the second pulmonary sound accentuated. A soft, systolic murmur is frequently heard just outside the left nipple line. Dilatation may develope very rapidly, and may be accompanied by muscular weakness, pallor and dyspnœa. The author deals with the heart in pneumonia, in diphtheria, in scarlet fever, in enteric fever and in septic infection.

## NEUROLOGY.

### (134) Adductor Responses of the Leg.

A. Myerson has undertaken the study of various periosteal reflexes induced by percussing bones of the lower extremities, and marked by responses in the adductor muscles (*Journ. of Nervous and Mental Diseases*, February, 1916). His investigations have led him to conclude that adductor responses are present in health as mild and occasional homolateral and contralateral responses from the inner side of the knee joint, from the middle of the shaft of the tibia, from the internal malleolus, and from the Achilles tendon. Other sites, such as the sole of the foot, the patellar tendon, the external surface of the knee-joint and the anterior superior spine of the ilium, may be the starting points of adductor responses. Fatigue does not increase these responses, but diminishes them to the point of abolition. The appearance of contralateral adductor responses, especialy from the patellar tendon, the external condyle or the anterior superior spine, is usually a sign of disease and frequently of organic disease. The responses appear to have some relationship to the knee-jerk on the side of the muscles responding, but not to the knee-jerk on the side stimulated. He points out that the site of stimulation is probably not so important as the direction of the blow and the resultant stimulation of either hip-joint or pelvis, and that the part thus indirectly stimulated acts as the afferent limb of the reflex arc, the motor limb of which leads to the adductors. The adductor muscles probably belong to the tonic group of muscles and receive their innervation from sources other than the cerebrum. With the disappearance or diminution of cerebral influence, the tonus of these muscles is so increased that their reflex activity becomes greatly enhanced.

### (135) The Physio-Psychic Treatment of Alcoholic Intemperance.

On the ground that drug cures leave the moral nature uninfluenced, J. B. Quackenbos advocates treatment by suggestion in all cases of alcoholic intemperance (*The Medical Times*, Febraury, 1916). He claims, on an experience of 1,200 cases of alcoholic inebriety, that at least 80% of the patients who submit to psycho-therapy can be saved, and he is sanguine enough to suggest that the percentage of cures could be increased to 100 if all patients would carry out unremittingly the directions given. In about 20% of his patients no result was obtained. Some of them did not enter into the treatment with objective self-surrender; some of them already revealed the syndrome of alcoholic dementia, and some were society women, who, in his experience, were almost without the pale of hope. He maintains that the drink habit is growing, especially among the city women. Girls representing good families, conspicuously made-up, are not missing from the throng of the roof garden and of the misnamed *thé dansant*. Débutantes, not necessarily of a fast set, unblushingly assert a right to drink wine and smoke cigarettes at hotels and cafés. He states that not a few of this class, as well as young married women, have been brought to him in a state of intoxication. This applies to the well-to-do classes; the habit of drink, in so far as the great mass of the working people is concerned, is on the wane. He attributes this to the strenuous efforts of both Catholic and Protestant educators, to the necessity for economy and to the appreciation of the superior attractions of the moving picture show. The author takes to task those who drink to hide conditions that mortify, worry, depress or agonize. He points out that drink merely renders the dupe less capable of dealing with his difficulty, and does not alter the difficulties one iota. In dealing with his patients, he conducts them into the subliminal or sub-conscious sphere, and then suggests that they have lost all craving for stimulants; that alcohol is a virulent poison, and, as a safeguard, that they cannot swallow it. The society of alcoholic friends is forbidden; the pleasures of drink and of the saloon are pictured as meretricious, and the physical, mental, moral and economic bankruptcy accompanying intemperance is held up with realistic cogency before the view of the sleeper. He has found that even when the patient has entered the sleep reluctantly, with pronounced mental reservation, success may be obtained. He associates with the evil effect of alcohol that of cigarette smoking.

### (136) Herpes Zoster Oticus.

Norman Sharpe exhibited at the New York Neurological Society a patient who complained of severe pain in the right ear, headaches, dizziness, tendency to stagger and diplopia (*Journ. of Nervous and Mental Diseases*, February, 1916). After these symptoms had been present for a week he noticed some small pimples and facial palsy on the right side. On examination, there was loss of taste sense on the right half of the tongue, and there were small red spots on the right side of the mouth and of the fauces. The pain rapidly disappeared, but the right facial palsy persisted, and was associated with lateral nystagmus. The author regarded the case as one of herpes zoster attacking the sensory ganglia of the cephalic extremity. The eruption followed the distribution of the seventh, ninth and tenth nerves. The tenth nerve, however, could be eliminated, because of absence of nausea and vomiting. Moreover, there was no eruption over the mastoid or postero-mesial surface of the auricle.

### (137) Localization of Function in the Cerebellum.

Earnest G. Grey (*Journ. of Nervous and Mental Diseases*, February, 1916) has reviewed the studies on cerebellar localization. It appears that lesions in the *crus primum* of the *lobulus ansiformis* evokes symptoms in the homolateral forefoot. It has been stated that the crus is a foreleg centre. The *crus secundum* apparently corresponds to the homolateral hindfoot. Rynberk holds that destruction of the *lobulus paramediamus* leads to forced movements about the longitudinal axis of the body and to pleurothotonos. He has also asserted that lesions of the *lobulus simplex* give risè to a tremor of the head which persists for weeks or months. The author describes his methods of removal of various portions of the canine cerebellum and details the results of his experiments. He also enters into a discussion on the theory of cerebral compensation. Although circumscribed lesions of the cerebellar lobuli have yielded somewhat varying results in the hands of different investigators, he is of opinion that the complex movements necessary for standing, running, etc., are represented in more or less local areas in the cerebellar cortex. It has been shown that the gradual disappearance of symptoms following removal of the cerebellum does not occur in animals in which the sensori-motor spheres of the cerebrum have also been destroyed. When the sensori-motor areas are destroyed some weeks subsequent to a primary ablation of the *crus secundum* or the *lobulus simplex*, the symptomatic evidence of the injury will reappear and persist for a long period.

### (138) Function of the Red Nucleus.

T. Graham Brown (*Journ. of Physiology*, May, 1915) had previously shown that stimulation of certain points in the cross-section of the mid-brain at the level of the anterior colliculi yielded characteristic reactions in monkeys. Stimulation applied to one area in this cross-section evoked a state of flexion in the arm of the same side, and a state of extension of the arm on the opposite side. Accompanying these movements in the arms were movements of the legs and tail, with rotation of the face away from the side stimulated. These reactions have been confirmed and extended upon a decerebate chimpanzee. The triceps and supinator longus muscles have been isolated, and graphic records taken of their movements. Stimulation of the contralateral red nucleus evokes an extensor contraction that is maintained for some minutes. If the contralateral pyramidal tract is stimulated during the maintained extensor reaction, the flexor muscles contract, but the extensor muscles are not relaxed. When the stimulus is withdrawn there is both flexor and extensor relaxation.

# British Medical Association News.

## ANNUAL MEETING.

The Annual Meeting of the New South Wales Branch was held on March 31, 1916, at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, Dr. George Armstrong, the President, in the chair.

The Honorary Secretary moved the reception of the Annual Report of the Council. The motion was seconded by Dr. W. F. Litchfield, and carried.

### Annual Report of the Council.

The Council has the honour to present the following report upon the work of the Branch for the year ended March 31, 1916:—

*Membership.*—The membership of the Branch is now 974. At the time of last year's report it was 968. The losses during the year have been as follows:—by resignation, 10; by removal out of the area of the Branch, 28; by expulsion, 4; by non-payment of subscriptions, 44; by death, 10. The losses by death were as follows:—Dr. W. Collings Dawson, Dr. C. L. Handcock, Dr. H. O. Johnson, Dr. W. H. Kaye, Dr. C. J. Kearney, Dr. H. Kirkland, Dr. J. Lamrock, Dr. W.. Odillo Maher, Dr. Muir P. Smith, Dr. T. F. Wade.

*Meetings.*—Eleven Ordinary Meetings, including the Annual Meeting, with an average attendance of 32, and three Extraordinary Meetings, with an average attendance of 58 were held. There were also six Clinical Evenings, with an average attendance of 21. At the Ordinary Meetings and Clinical Evenings the business included 33 papers, 1 exhibits, 17 reports of cases, and 2 lantern demonstrations. At three of the Ordinary Meetings and at all the Extraordinary Meetings matters of medical politics were dealt with. Fifteen meetings of the Council were held, including four regular Quarterly Meetings. In addition the meetings of the Standing Committees of the Council were as follows, viz.:—Executive and Finance Committee, 13; Organization and Science Committee, 13; Ethics Committee, 14; Medical Politics Committee, 14. There were also several meetings of sub-committees convened for particular purposes. The Medical Journal Sub-Committee of the Executive and Finance Committee held regular meetings since its creation on 18th May, 1915.

*Representation.*—The Branch was represented on other bodies as follows:—(*a*) On the Council of the British Medical Association by Dr. C. J. Martin (Lister Institute). (*b*) On the Representative Body by Dr. David Thomas. (*c*) On the Federal Committee of the British Medical Association in Australia by Dr. G. H. Abbott and Dr. David Thomas, Dr. W. H. Crago being Dr. Thomas' substitute during his absence from Australia. (*d*) In the Australasian Medical Publishing Company, Limited, by Dr. W. H. Crago, Dr. R. H. Todd, Dr. G. E. Rennie (resigned 21st May, 1915), Sir H. L. Maitland (nominated 22nd May, resigned 22nd December, 1915), Dr. F. P. Sandes (nominated 20th January, 1916). (*e*) On the Council of the New South Wales Bush Nursing Association, by Dr. George Armstrong. (*f*) State Medical War Committee (Disablement Sub-Committee of the State War Council), by Dr. George Armstrong, Dr. W. H. Crago and Dr. R. H. Todd.

*Council.*—The constitution of the Council was as follows:—Drs. George Armstrong (President), R. Gordon Craig (Vice-President), Sinclair Gillies (Acting Vice-President during absence of Dr. R. Gordon Craig), G. H. Abbott (Hon. Medical Secretary), Fourness Barrington, E. H. Binney, C. B. Blackburn, A. J. Brady, W. H. Crago (Hon. Treasurer and Acting Hon. Librarian during Dr. J. Adam Dick's absence), J. Adam Dick (Hon. Librarian), Sydney Jamieson, T. W. Lipscomb, W. F. Litchfield, Sir H. L. Maitland, Drs. F. Antill Pockley, Clarence Read, F. P. Sandes, R. Scot-Skirving, David Thomas (Ex-President), and R. H. Todd (Hon. Secretary).

The Representatives of the Local Associations of Members appointed by their respective Local Associations on the invitation of the Council to attend the regular Quarterly Meetings of the Council were as follows:—Dr. E. A. R. Bligh (Northern Suburbs Medical Association), Dr. G. H. Walton Smith (Eastern Suburbs Medical Association), Dr. S. S. Shirlow (Balmain District Medical Association), Dr. F. C. S. Shaw (Southern District), Dr. H. Busby (Western), Dr. L. M. Snow (Northern District), Dr. W. C. McClelland (South Sydney), Dr. A. Maitland Gledden (City), Dr. J. Kearney (Central Western), Dr. J. J. O'Keefe (Illawarra Suburbs), Dr. C. H. E. Lawes (Western Suburbs).

*B.M.A. Building.*—The management of the B.M.A. Building has continued in the hands of Dr. W. H. Crago, acting under Power of Attorney from the Branch, with the advice of the Executive and Finance Committee.

*The Library.*—During the absence of Dr. J. Adam Dick on military service in the A.A.M.C., the duties of Hon. Librarian have kindly been undertaken by Dr. W. H. Crago, the immediate supervision of the books being in the hands of Miss A. L. Whitfeld.

*Affiliated Local Association of Members.*—Despite the strain on the members throughout the State consequent upon the absence of so many of their colleagues on military service, the work of the Local Associations of Members, excepting the Eastern District and the South-Eastern Medical Association, has been well maintained. The following is a list of the Affiliated Local Associations of Members and their Secretaries:—

| | |
|---|---|
| Northern Suburbs | Dr. E. A. R. Bligh, North Sydney. |
| Eastern Suburbs | Dr. J. C. Hughes, Centennial Park. |
| Western Suburbs | Dr. J. F. Walton, Petersham. |
| South Sydney | Dr. H. H. Parkinson, Redfern. |
| City | Dr C. E. Corlette, Sydney. |
| Illawarra Suburbs | Dr. W. J. Binns, Kogarah. |
| Balmain District | Dr. W. Brodie Grant, Rozelle. |
| Border | Dr. R. A. Robertson, Albury. |
| Western | Dr. L. W. Roberts, Orange. |
| Central Western | Dr. E. C. Hall, Parramatta. |
| North Eastern | Dr. R. V. Graham, Lismore. |
| Northern District | Dr. E. W. Buckley, Tamworth. |
| Eastern District | Dr. F. O. Stokes, Taree. |
| Central Northern | Dr. H. G. Allen, Newcastle. |
| Southern District | Dr. W. W. Martin, Wagga Wagga. |
| South Eastern | Dr. W. L. Kirkwood, Wollongong. |
| Central Southern | Dr. G. A. Buchanan, Goulburn. |

*Annual Meeting of the Delegates of the Local Associations of Members with the Council.*—The fourth Annual Meeting of the Delegates of the Affiliated Local Associations of Members with the Council was held on 1st October, 1915, at the B.M.A. Library, Sydney.

The Delegates were as follows:—Dr. L. W. Roberts (Western), Dr. Harold Browne (Western Suburbs), Dr. E. A. R. Bligh (Northern Suburbs), Dr. G. A. Buchanan (Central Southern), Dr. E. C. G. Page (North Eastern), Dr. O. E. B. Withers (Central Western), Dr. A. Maitland Gledden (City), Dr. R. A. Robertson (Border), Dr. W. C. McClelland (South Sydney), Dr. J. MacPherson (Eastern Suburbs), Dr. W. W. Martin (Southern District).

A report of the proceedings was published in the *Medical Journal of Australia*, October 9, 1915, p. 353.

*Friendly Society Lodge Practice.*—The second year's experience of the approved Common Form of Agreement for use between Medical Officers and Friendly Society Lodges has still further emphasized the advantage both to the F. S. Lodges and their Medical Officers of uniformity throughout the State in the terms and conditions of this form of contract practice. A very large number of the Lodges which had preferred to make arrangements with practitioners who were not members of the Association have, during the past year invited members of the Association to give their services. The Agreement also has worked well. It is, however, proposed by the Council to invite the members to amend it in regard to the provisions of Clause 5 in reference to the removal, during the currency of a quarter, of names from the list of members to be attended by the Medical Officer. The proposed amendment is the addition to Clause 5 of the following words, namely:—

> "In the event of a member having removed to a distance of more than two miles from the Medical Officer's residence, and having become entitled under the provisions of Clause 21 hereof to the Medical Benefit of a Lodge of the same or another Order or Society which meets in another place, the Medical Officer, on being duly notified in writing to that effect by the Secretary, shall forthwith remove such member's name from the list of members to be attended by him, and payment in respect of such member shall be made to the Medical Officer only up to the end of the month in which such notification has been given."

It is proposed also to invite the members to empower the Council, subject to adequate safeguards, to sanction, under exceptional circumstances, exemptions from or modifications of the Agreement. The motion to be submitted for the purpose is as follows, namely.—

> "That the Council of the Branch be empowered to use its discretion in regard to the exemption of particular Lodges or particular members from the operation of the Common Form of Agreement between Medical Officer and Friendly Society Lodge, and in regard to sanctioning modifications of the Agreement to suit particular places and particular circumstances: provided that no such discretion be exercised without the concurrence of the Local Association concerned.

*The Australasian Medical Gazette.*—Dr. W. H. Crago has continued his services as Manager of *The Australasian Medical Gazette*, now incorporated in *The Medical Journal of Australia.*

*The Medical Journal of Australia.*—*The Medical Journal of Australia*, conducted by the Australasian Medical Publishing Company, Limited, and published in Sydney, has appeared regularly week by week as the official organ of the New South Wales Branch as of all the other Branches of the Association in Australia. The Council trusts that the members of the Branch will do all that is in their power to assist the Company in making its Journal more and more useful to the profession as time advances.

*Legislation.*—The following Acts of Parliament directly affecting the Medical profession were passed during the year, namely:—(*a*) Public Health (Amendment) Act, 1915, No. 7. This Act makes pulmonary tuberculosis a notifiable disease, and requires the medical attendant in a case of pulmonary tuberculosis to examine the sputa, and to notify the Board of Health in the event of his having reasonable ground for believing that the sputa contain tubercle bacilli. (*b*) "Medical Practitioners (Amendment) Act, 1915." This Act excludes from registration practitioners qualified in countries which do not grant the right to practise therein in virtue of Registration as a legally qualified medical practitioner in New South Wales. The effect of the provision appears to be to bar all qualifications except those of the United Kingdom and Australia, and possibly New Zealand; although holders of such qualifications may be registered upon their passing the examination prescribed by the University of Sydney.

*Regulations.*—Regulations governing sections for special Branches of Medical Knowledge were passed at a General Meeting of the Branch held 25th June, 1915, so that it is now possible for groups of members specially interested in particular branches of medicine or surgery to be organized as sections under the rules of the Association.

In accordance with the action taken by the British Medical Association at the Annual Representative Meeting, held in July, 1915, in reference to the subject of Professional Secrecy, the Council, at its Quarterly Meeting, October 5, 1915, passed the following resolution, namely:—

> "That the Council is of opinion that a medical practitioner should not, under any circumstances, disclose, except under compulsion of law, without the patient's consent, information which he has obtained from that patient in the exercise of his professional duties."

The Council also directed that a memorandum should be sent to the members, conveying this resolution, together with a statement "That the Council is advised that the State has no right to claim that an obligation rests upon a medical practitioner to disclose, except under compulsion of law, information which he has obtained in the exercise of his professional duties."

*Medical Politics.*—The chief matters of a controversial nature in connexion with Medical Politics which occupied the Council during the year have been (*a*) a proposal by the Department of Public Instruction to provide the State Public Schools with medical attendance at the hands of whole-time and part-time salaried medical officers; (*b*) Baby Clinics. In regard to the former, meetings of the Association were convened for the purpose of ascertaining the views of the members, and the following resolutions were passed, namely:—

> "That the Association is strongly opposed to any of its members accepting any of the appointments as Medical Officers, Ophthalmic Surgeon, Ear Nose and Throat Surgeon, Physician, under the Department of Public Instruction, now being advertised, unless the Government gives sufficient guarantees that the treatment of the school children will be confined to those whose parents are unable to afford to pay for medical attendance of the kind indicated, and that the rights of private medical practitioners will be preserved; and that, the Minister having written to the effect that it is the intention not to make any discrimination on the ground of the financial circumstances of the children, the appointments be declared inimical to the interests of the medical profession." (January 14, 1916.)
>
> "That the Association is opposed to State interference with the recognized system of medical practice and treatment as being against the best interests of the community."
>
> "That any appointments of Medical Officers prejudicial to the recognized system be declared inimical to the interests of the profession."
>
> "That the Association approves of the medical inspection but not treatment of school children by Government Departmental Officers." (February 4, 1916.)

In reference to Baby Clinics these were first established as public institutions in 1914. They are now being developed under a Departmental Board entitled "The Baby Clinics, Pre-Maternity and Home Nursing Board." So far, nine Clinics have been established, each with its Medical Officer. The duties of the Medical Officer are not defined; and there appears to be some risk that the Clinics may degenerate into irregular institutions for the treatment of disease not only in babies but in children up to the age of puberty. A conference was held between the Council, the Medical Practitioners who are members of the Board, and the Medical Officers of the Clinics. It is hoped that the action of the Council will be effective in placing these institutions on a more satisfactory basis.

*War Emergency Organization.*—(*a*) Civil Practice: Throughout the period under review the conditions of medical practice have been subject to adjustments in many localities necessitated by the departure of a large number of members on military service. It was not found either practicable or desirable that the Branch should undertake arrangements for carrying on the practices of absent members. It was, in fact, recognized that such arrangements were more satisfactorily made by those immediately concerned. The Council congratulates the members on the admirable spirit which has prevailed in this connexion, and the readiness shown on every hand to give the fullest effect to the resolution of the Branch passed on August 28, 1914, as follows:—

> "That with a view to conserving the interests of members of the Branch who undertake Naval or Military Service during the existing state of war, the rest of the members individually engage—in the event of being called upon to fill their positions or attend their patients—to restore the same to them upon their return to civil practice so far as it may be in their power so to do."

(*b*) Attendance upon Soldiers enlisted for Active Service after discharge from hospital in country and other districts where no Military Hospital is established:—The Defence Department took advantage of the organization of the Association for the purpose of arranging for the treatment of returned A.I.F. soldiers in places where there were no Military Hospitals. A scheme for the purpose, whereby the members gave their services gratuitously (the Department supplying drugs and dressings), was adopted at a meeting of the Branch held July 30, 1915, and this was subsequently accepted by the Minister. The scheme provided for attendance for six months from the date of the soldiers' return; but, by an instruction of a later date (25/10/15), the six months was reduced to three months as the period during which the Defence Department provided medical treatment.

(*c*) Classification of Members for A.A.M.C. purposes:—At the invitation of the Federal Committee of the British Medical Association in Australia, a special organization of the members of the Branch for military purposes was undertaken. A circular letter (22/7/15) was sent to mem-

bers inviting them to complete and return a form, setting out the various ways in which they might indiviually make their services available. The response was good, and the information was classified and delivered to the P.M.O., to whom it has proved of the greatest utility. The classification has also been in constant use by the Council in the numerous applications made to it for assistance in obtaining A.A.M.C. officers.

## BRITISH MEDICAL ASSOCIATION—NEW SOUTH WALES BRANCH.

### Receipts and Expenditure for the Year ended December 31, 1915.

**Receipts.**

| | £ | s. | d. |
|---|---|---|---|
| Jan. 1, 1915— | | | |
| To Balance | 554 | 3 | 0 |
| „ Subscriptions | 3,308 | 3 | 10 |
| „ Sales (C.F.A.) | 15 | 2 | 5 |
| „ Interest | 49 | 7 | 10 |
| | £3,926 | 17 | 1 |

**Expenditure.**

| | £ | s. | d. |
|---|---|---|---|
| By British Medical Association | 912 | 8 | 6 |
| „ The Medical Journal of Australia | 800 | 0 | 0 |
| „ Clerical Assistance | 679 | 18 | 9 |
| „ Rent | 83 | 2 | 0 |
| „ Printing | 98 | 14 | 1 |
| „ Postage | 88 | 4 | 0 |
| „ Library | 54 | 10 | 0 |
| „ Typewriter | 19 | 10 | 0 |
| „ Sundries | 45 | 13 | 11 |
| „ Attendance at Meetings | 19 | 0 | 0 |
| „ Telephone | 4 | 3 | 9 |
| „ Travelling Expenses | 9 | 14 | 2 |
| „ Exchange and Bank Charges | 11 | 3 | 5 |
| „ Advance to Premises Account | 850 | 0 | 0 |
| „ Balance | 250 | 14 | 6 |
| | £3,926 | 17 | 1 |

FRED. W. HALL
A. MAITLAND GLEDDEN, } Auditors.

W. H. CRAGO,
Hon. Treasurer.

The Honorary Treasurer presented the financial statement, and moved its adoption. After the motion was carried, he gave some details regarding the premises account. During the course of the year the 4½% mortgage of £15,750 had been reduced by £1,000. On the other hand, the only alteration in the debenture account was the redemption of one £10 debenture. The net profit for the year amounted to £392, which, together with the balance brought forward from the previous year, was increased thereby to £1,723. The assets amounted to close on £31,000, after various sums for depreciation of lift and furniture had been written off. In the revenue account, it was shown that rates and taxes and wages were increasing, and Dr. Crago pointed out that further increases in wages would have to be met in the current year. The rents of offices let amount to £3,063. The members expressed gratification at the satisfactory state of the undertaking.

The Honorary Treasurer moved a vote of thanks to the Auditors, Drs. Fred W. Hall and A. Maitland Gledden, which was carried by acclamation.

### President's Address.

The President, Dr. George Armstrong, delivered his address (see page 297).

Dr. Sinclair Gillies, the President Elect, moved a hearty vote of thanks to Dr. Armstrong for his able address, and paid a glowing tribute to his valuable services as President of the Branch. He endorsed the opinion expressed by one of his colleagues on the Council that Dr. Armstrong was leaving the Presidential Chair with more friends than he had had when he entered it.

Dr. A. J. Brady seconded the motion, which was carried by acclamation.

### Office Bearers.

The President declared the result of the election of the office bearers and members of Council as follows:—

*President*: Dr. Sinclair Gillies.

*Vice-President*: Dr. R. Gordon Craig.

*Members of Council*: Dr. G. H. Abbott, Dr. George Armstrong, Dr. Fourness Barrington, Dr. E. H. Binney, Dr. C. D. Blackburn, Dr. A. J. Brady, Dr. W. H. Crago, Dr. Andrew Davidson, Dr. J. Adam Dick, Dr. Sydney Jamieson, Dr. T .W. Lipscomb, Dr. W. F. Litchfield, Dr. A. A. Palmer, Dr. F. Antill Pockley, Dr. F. P. Sandes, Dr. R. Scot Skirving, Dr. David Thomas, Dr. R. H. Todd.

Dr. E. H. Binney moved a vote of thanks to the scrutineers, and the Honorary Treasurer moved that Drs. F. W. Hall and A. Maitland Gledden be appointed Auditors for the ensuing year. Both motions were carried.

Dr. Todd, the Honorary Secretary, moved, and Dr. Lipscomb seconded, that Dr. Clarence Read be appointed Representative of the Branch on the Representative Body of the British Medical Association. The motion was carried unanimously.

### Common Forms of Agreement.

The Honorary Secretary moved:—

> "That the Council be empowered to use its discretion in regard to the exemption of particular Lodges or particular Members from the operation of the Common Form of Agreement between Medical Officer and Friendly Society Lodge, and in regard to sanctioning modifications of the Agreement to suit particular places and particular circumstances; provided that no such discretion be exercised without the concurrence of the Local Association of Members concerned."

He pointed out that it was inevitable that inequalities should exist in regard to Lodge practice for some time after the introduction of the Common Form of Agreement. He was glad to say that the Common Form had been adopted over the greater part of the State, and was working well, and that minor inequalities had produced but few hardships. It was felt, however, that the time had arrived when the Council might be empowered under very rare conditions in certain limited districts to adjust the agreement to local circumstances. The motion he was proposing had been discussed at two meetings of the delegates of the Local Medical Associations, and in October, 1915, it had been carried by a large majority. The Council had considered the question, and had come to the conclusion that it should recommend its adoption by the Annual Meeting. He pointed out that the safeguard against abuse was contained in the last sentence.

Dr. A. J. Brady seconded the motion, and gave support to the recommendation.

A discussion ensued, in the course of which Drs. R. E. Woolnough and R. W. McCredie pointed out the dangers and the inadvisability of introducing modification into the Common Form of Agreement. They voiced the opinions of those who had suffered financially from the introduction of the Common Form of Agreement. They received the assurance, however, of various members of the Council that modifications would not be introduced, save under the very rarest conditions and in special circumstances. The motion was carried without dissent.

The Honorary Secretary moved:—

"That the Common Form of Agreement between Medical Officer and Friendly Society Lodge be amended by the addition to Clause 5, at the end thereof, of the following words, namely:—

'In the event of a Member having removed to a distance of more than two miles from the Medical Officer's residence, and having become entitled, under the provisions of Clause 21 hereof, to the Medical Benefit of a Lodge of the same or another Order or Society which meets in another place, the Medical Officer, on being duly notified in writing to that effect by the Secretary, shall forthwith remove such member's name from the list of members to be attended by him, and payment in respect of such member shall be made to the Medical Officer only up to the end of the month in which such notification has been given.'"

The motion was seconded by Dr. Crago, and carried.

**Induction of President.**

Dr. George Armstrong introduced Dr. Sinclair Gillies as President for the ensuing year, and vacated the chair in his favour. On assuming the chair, Dr. Sinclair Gillies made a few appropriate remarks.

**The Medical Benevolent Fund of New South Wales.**

At the Annual Meeting of the New South Wales Branch, the office bearers and committee of the Medical Benevolent Fund were re-elected as follows:—

*Trustees*: Dr. Robert Faithfull and Dr. F. W. Hall.
*Hon. Secretary*: Sir Herbert Maitland.
*Hon. Treasurer*: Dr. R. L. Faithfull.
*Members of Committee*: Dr. F. W. Hall, Dr. Gill.

Dr. THE TREASURER, IN ACCOUNT WITH THE NEW SOUTH WALES BENEVOLENT FUND. Cr.

| 1916. | £ s. d. |
|---|---|
| Balance Brought Forward from March 31, 1915 | 157 5 5 |
| Subscriptions from March, 1915, to March, 1916 | 30 10 6 |
| | £187 15 11 |

H. L. MAITLAND

| 1916. | £ s. d. |
|---|---|
| Money Disbursed to Deserving Cases (including £50 Belgian Doctors' Relief Fund) as directed by Committee from March 12, 1915, to June, 1915 | 66 0 0 |
| Bank Fees | 0 10 0 |
| Exchange | 0 2 0 |
| Cheque Returned | 0 10 6 |
| Stamps and Printing | 2 19 10 |
| Balance as per Pass Book £183 13 5 | |
| Less Cheque paid to Sir Herbert Maitland for cash paid out of his pocket 65 19 10 | |
| | 117 13 7 |
| | £187 15 11 |

| | £ s. d. |
|---|---|
| At Deposit in Savings Bank of N.S.W., Barrack Street, as per Pass Book, plus Interest to June 30, 1915 | 300 9 5 |
| Balance at Credit Current Account, Commercial Banking Co. of Sydney, Bathurst Street Branch, as per Pass Book | 117 13 7 |
| Total correct at this date | £418 3 0 |

Audited and found correct—
GEORGE BELL

## MEDICO-POLITICAL.

A meeting of the Council of the Victorian Branch was held on March 29, 1916, at the Medical Society Hall, East Melbourne, Professor Berry, Vice-President, in the chair.

Various matters of medico-ethical importance were dealt with.

The members considered various enquiries by practitioners in regard to the Workers' Compensation Act. It appears that claimants under the Act were required by Insurance Companies to obtain a medical certificate on a form, at the bottom of which was printed "The claimant must pay for the medical certificate." The medical practitioners were anxious to know to whom they should look for payment for the certificate. According to the Act the employer requiring a certificate must pay for the same. The matter had been referred to a Sub-Committee for an interpretation of the clause bearing on this matter. This Sub-Committee submitted the following opinion:—

If employers or Insurance Companies want certificates they must pay for them. If they demand certificates from medical practitioners who are "certifying medical practitioners" the fee is 7s 6d; but a medical practitioner need not give more than the certificate. If he is asked to give a report he can charge his own fee.

Dr. Keith S. Parker, Manly, has been nominated for election to the New South Wales Branch.

## BELGIAN DOCTORS' RELIEF FUND.

The Treasurer of the Queensland Branch has received a contribution of £2 2s. from Dr. A. J. Turner towards the Belgian Doctors' Relief Fund.

## THE FEDERAL SERUM INSTITUTE.

We have been informed that Dr. William James Penfold, late Assistant Bacteriologist at the Lister Institute of Preventive Medicine, has been appointed Director of the Federal Serum Institute. Dr. Penfold's contributions to the study of fever and of numerous other bacteriological subjects have obtained for him the reputation of a capable and earnest worker, and his experience at the Lister Institute and elsewhere will form a valuable asset to the institution under his charge.

## CAUSES OF DEATH AND INVALIDITY.

**Preliminary Report of Federal Departmental Committee.**

The terms of the reference to the Committee are as follows:—

(1) The collection of evidence as to causes of death in Australia; the consideration of the principal causes of death, and the indication of the general directions in which the reduction of such causes of death may

reasonably be anticipated by the application of suitable measures.

(2) The indication of the general nature of suitable measures for the investigation and the prevention of the principal causes of death or invalidity.

The reference to the Committee does not include the preparation of any précis of the steps already taken by the Parliaments and the various health authorities to combat the causes of death and invalidity. Your Committee, while appreciating the value and results of these activities, will refer to past history only so far as may be found necessary in dealing with present problems.

Many questions at once present themselves that may claim attention. Some of these may be stated forthwith:—

### Infantile Mortality.

Notwithstanding the marked improvements that have been wrought, why is the mortality among babies under twelve months so much greater in the Commonwealth of Australia than in New Zealand? The lowest rate yet recorded for Australia per 1,000 births is 68.49 in 1911, while New Zealand had a rate of only 51.4 in 1914. Why has Queensland, with a mean annual temperature, even at Brisbane, of 68.9° F., the lowest rate in the Commonwealth (63.93), while Victoria, with a mean annual temperature at Melbourne of 58.3° F., has the highest rate (78.27)? As a rule, a high death-rate among babies coincides with a high-birth rate, but the birth-rate per 1,000 of mean population is 29.46 in Queensland and only 25.45 in Victoria.

### Falling Birth-Rate.

Can the birth-rate in the Commonwealth (28.05) be accepted as satisfactory, while it is 32.4 in Italy (1912), 43.4 in Roumania (1912), and 44 in European Russia (1909)? Why has the rate fallen, for instance, in New South Wales from 43.93 in 1864 to 28.96 in 1914, and in Victoria from 38.07 in 1870 to 25.45 in 1914?

### Puerperal Mortalities.

What is the explanation of the persistent high rate of mortality of women in childbirth? In well-managed maternity hospitals, the mortality from septic puerperal infection has been almost abolished. Yet in 1914, 634 women died in the Commonwealth from causes connected with the puerperal state, or 4.6 per 1,000 children born, 215 of these deaths being registered as due to septic infection, and 22 others as due to phlegmasia and allied causes, which may be treated as septic. The Victorian rate is the lowest, but its 4.1 is not far removed from the maximum of 4.9 in New South Wales.

### Tuberculosis.

The death-rate from tubercle has been reduced by one-half within the last forty years, but in 1914 no less than 3,674 deaths in the Commonwealth were attributed to this one cause. For several years the tubercle rate has been practically stationary. Is it not possible again to cut the rate by one-half? The loss from this cause is widely distributed over all age periods. The maximum number of deaths (470) for any quinquennium occur between 25 and 29; but between 50 and 54 the deaths number 281, and between 60 and 64 the deaths are 141. Even people of advanced age are not exempt. The importation of active tubercle into the Commonwealth is not great. Out of 3,674 who have died, 2,582 were born within the Commonwealth, and 483 others have lived therein for 20 years or more. In only 41 has the period of residence been less than one year, and in only 158 less than 3 years. The 65 deaths of children under one year of age in 1914 from various forms of tuberculosis also merit attention, as also does the comparatively high percentage of tuberculosis of the bones and joints amongst the causes of invalidity.

### Industrial Diseases.

The subject of the industrial diseases is vast and complicated. Many of its problems are included among the conditions favouring or preventing tuberculosis. But the group of dust diseases needs special treatment, and within this group attention is chiefly called to the nature, prevalence and prevention of miners' disease.

### Cancer.

Enquiries into the causation of cancer have not been very fruitful. Yet in the Commonwealth cancer causes as many deaths as tubercle. In 1914, the numbers were almost identical, 3,674 from tubercle and 3,675 from cancer. But while tubercle is a common cause of death at all ages, the incidence of cancer is mainly on those past middle life, the greatest number of deaths occurring between 55 and 70. The stomach is most frequently affected, and in men more than in women. The uterus and the breast in women come next in order of prevalence. Then come the bowels, which are affected almost equally in the two sexes. There are, however, certain points concerning cancer which must engage the attention of the Committee.

### Enteric Fever.

There has been a marked improvement in the statistics of enteric fever in the Commonwealth. For instance, in Greater Melbourne the mortality from this cause per 100,000 of population was 78.4 in 1881-1890, 31.8 in 1891-1900, and only 7.0 in 1909-1913, with a minimum of 4.5 in 1913. But why should the number of cases reported in the Melbourne Metropolitan District (1909 to 1913) be 67 per 100,000 of population, while that of the remainder of Victoria was 143, or over twice as many? Why should the death-rate from enteric fever in the country district of New South Wales be one-third greater than in the metropolitan district of Sydney? Why should New South Wales, with 1,861,522 inhabitants, have 246 deaths from this cause (132 per million), while Victoria, with 1,430,677 people, has only 107 deaths (74 per million)?

### The Problem of Carriers.

We congratulate ourselves that so many children with diphtheria are saved by injections of antitoxin; but why is diphtheria so widespread over the Commonwealth, the deaths attributed to diphtheria and croup in 1914 reaching a total of 716. The highest death-rate in any State of the Commonwealth in recent years was recorded in Tasmania. About 5,000 cases are recorded annually in Victoria alone, the number having doubled since 1910.

The spread of enteric fever, diphtheria, and cerebro-spinal fever by carriers is generally recognized. Consideration will be given to the question as to what steps should be taken to diminish the number of carriers, and to lessen the mischief wrought by them.

### Diseases Connected with High Blood Tension.

The relative mortalities of males and females are in many respects suggestive. In 1914, the male death-rate for the Commonwealth was 11.67 per 1,000, and the female rate 9.27. In 1904 the corresponding rates were 12.12 and 9.88. The disparity becomes more marked if particular age groups are selected. The difference between the sexes is not as between children or young adults. It is at its greatest after middle life. In 1914, between the ages of 40 and 59, the deaths among men were 6,546, and among women 3,810. The death-rate among women within these ages was 1 in 109.3, while that of men was 1 in 77.6. If we call the death-rate within these ages for women 100, the corresponding rate for men was 140.8.

In 1914 three years had elapsed since the census of 1911. Hence the age and sex distribution of the population was a matter of inference. In the census year itself, however, the relative rates for those ages were almost exactly the same. The disproportion is more marked in some States than in others. The relative male rate for these ages is specially high in Queensland and Western Australia.

In these age periods, the death-rates are high from apoplexy, from pneumonia, from Bright's disease, and from organic diseases of the heart. Excessive tension of blood within the arteries prevails in striking frequency within these age limits.

What lessons lie behind these facts? It must be remembered that though men suffer in greater numbers from the diseases now under consideration, women are by no means exempt. The evils wrought by high blood tension and the conditions associated with it are extremely widespread.

### Local Inequalities in Mortality Rates.

Apart from questions of age, inequalities in the mortality rates of the several States suggest enquiry. The general rate per thousand of mean population varies from 9.41 in Western Australia to 11.59 in Victoria, the male rate from 10.35 in Tasmania to 12.65 in Victoria, the female rate from 7.75 in Western Australia to 10.53 in Victoria. Differences in age distribution complicate the question. For example, the populations of Victoria and of New South Wales are as 7 to 9. Yet in 1914 there were 709 more deaths of persons aged from 75 upwards in Victoria than in New South Wales.

If we turn to the mortalities of particular districts, there is much food for thought. Why, for example, should the death-rate for the Melbourne metropolitan district in 1914 per 1,000 residents be 12.21 while that for Stawell was 17.80, Ballarat and suburbs 17.51, and Bendigo and suburbs 16.46? Why should the rates within Greater Melbourne vary in the same year from 8.55 in Preston Shire and 9.60 in Malvern City to 14.76 in Melbourne City and 14.44 in Fitzroy City? These figures will be examined in detail at a later stage, in comparison with similar statistics from other parts of the Commonwealth.

**Alcohol and Venereal Infection.**

Such questions as have hitherto been indicated arrest attention on a brief study of published statistics. But there are other questions of great importance on which ordinary statistics throw little light. Pre-eminently is this the case with alcohol and syphilis and gonorrhœa. Few deaths are certified as due to these causes. But what is the real toll of death and disease and incapacity levied by these agents? In the opinion of your Committee, enormous power for evil should be attributed to them, and it is proposed to discuss these causes in some detail at a later stage

**General Factors.**

When ultimate causes of disease are sought, the problems become very extensive. Climate, soil, housing and ventilation, food, water supply, drainage, disposal of refuse, exercise, social habits, these and other factors cannot be forgotten; care for the teeth, the throat and the organs of digestion assume a value that is recognized more fully as knowledge increases.

**Work of the Committee.**

Your Committee proposes to discuss, one after another, some at least of the problems indicated in this preliminary report, but not necessarily in the order in which they have been mentioned.

The statistics given in this preliminary report are mainly based on those published by the Commonwealth Statistician in Bulletin No. 32, on population and vital statistics, entitled "Commonwealth Demography, 1914 and Previous Years." Other statistics are taken from the Official Year Book of the Commonwealth and of the several States.

## Correspondence.

### POSTURE IN ANÆSTHESIA.

Sir,—May I correct what appears to me a statement that is slightly misleading in your sub-leader on "Posture in Anæsthesia."

"He advocates the adoption of this posture (*i.e.*, sitting upright) in administering general anæsthetics."

This reads as if I advocated this sitting upright position in all cases.

I endeavoured in my notes to your paper of March 18 to make myself clear. It is at the Melbourne Dental Hospital, and also in our short anæsthetic cases in the H.M.A.S. *Australia* that we used the sitting-up position, and found it of the greatest service; in these cases mainly somnoform or ethyl chloride were the anæsthetics employed.

In our other cases, which are of longer duration, and where the anæsthetic generally employed is open ethyl chloride, followed by open ether, I strongly advocate the raising of the head and shoulders on a gentle slope of from four to six inches. This position is the general rule I follow.

If the patient is a strong, robust male, and looks the sort of case to cause possible trouble during induction, then he may have the head and shoulders raised at a natural angle, to as much as 40° or 45°, with a distinct gain in the comfort and ease of induction.

After induction, the anæsthetist can lower the head to a more gentle slope, *viz.*, one of about four inches above the level of the rest of the body; of course, there are numbers of cases in which the slightly raised level cannot be maintained throughout the whole operation, as in numerous abdominal operations. A patient who has had anæsthesia induced under the old head low position, *i.e.*, on the level, and also under the position with the head and shoulders raised at a natural angle, will, if he should require to have an anæsthetic the third time, always ask to have the head up position. There is no comparison from the patient's and also from the anæsthetist's point of view in the two positions; in the one position it is a comparatively pleasant, in many cases a very pleasant induction, in the other it is more nearly approached to hell—a milder term would not express it. If I had my own way I would like to see that every student had an anæsthetic administered to him before he should be permitted to give anæsthetics on his own; he would then be able to appreciate more fully the sensations of his patient when going under the influence of an anæsthetic, and to appreciate that if improperly handled induction to the anæsthetic stage is not all unmixed joy.

Again, when my patients are removed from the operating table they are never permitted to be carried upstairs feet foremost, *i.e.*, standing on their heads, but they are carried up in the natural position of head first. When placed in bed they are not without a pillow, but are placed with the head and shoulders raised at a natural angle of three or four inches, the head is rotated over to one side, and care is taken to see that there is no kink in the neck, which will occur if only the head is placed on a pillow. If there is any tendency to post-operative vomiting, the head end of the bed is raised on blocks from six to eight inches in height.

Post-operative vomiting is, however, almost a thing of the past, or should be, and I have personally not seen a severe case for some years, that is, since full attention has been given to these details. The patients, as a rule, do vomit once, and, personally, I prefer that they should do so, as, by this means, they get rid of a lot of the anæsthetic, but any prolonged vomiting is very rare indeed, and, if it does set in, can generally be stopped by up-ending the head end of the bed.

I regret having taken up so much of your valuable space, but the position of the patient during induction, during operation, and following operation, is one of the most important for the carrying out of successful anæsthetic work; it is also necessary to be combined with careful, gentle, but not necessarily slow, work on the part of the operator. That is, the avoidance of all unnecessary roughness, even when the patient is fully under an anæsthetic.

A rough operator leads to increased difficulties in the administering of an anæsthetic, and increased dangers for the patient and increased risk of post-operative vomiting.

The patient should also be anæsthetized on the table on which he is to be operated upon, the mere shifting of the patient from the stretcher to the operating table may upset the even course of an anæsthesia, and induce retching, nor should the nurse be permitted to draw the patient roughly into the lithotomy or Trendelenburg position. She should first enquire of the anæsthetist if he is ready for the shifting of the patient, and the patient should then be drawn into position without any sudden jerks.

A patient should be handled with just as great care when under an anæsthetic as if he was not under.

It is by attention to the small details, both on the part of anæsthetist and surgeon, that the consumption of the amount of anæsthetic is kept down to a minimum, and the risk of post-anæsthetic poisoning reduced, with gain to all concerned and a rapid convalescence favoured.

Yours, etc.,

R. W. HORNABROOK.

March 27, 1916.

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Sir,—I read with much interest and appreciation Dr. Hornabrook of 18th instant. It is an ideal article, well reported, and admirably reasoned. It reminds me of a lecture when at Edinburgh by Sir Thomas Annandale, "My Failures and Bad Luck." When I was at Leeds I remember a case in which the Senior House Surgeon, now Sir Berkeley Moynighan, in precisely similar circumstances, cut down rapidly into the upper abdomen, and with his closed fist applied rhythmic impulses to the heart through the diaphram. I have never seen this procedure reported or discussed, but, judging by the result in the case mentioned, and the little risk of the incision under modern conditions it is well worth trying as "a dernier resort."

Yours, etc.,

Harden, N.S.W., C. C. BAXTER TYNE, M.Ch.

March 27, 1916.

## Books Received.

A MANUAL OF SURGICAL ANÆSTHESIA, by H. Bellamy Gardner, M.R.C.S., L.R.C.P., Second Edition, 1916. Baillière, Tindall & Cox; Demy 8vo., pp. 220. Price, 7s. 6d.

CONSTRUCTION, EQUIPMENT AND MANAGEMENT OF A GENERAL HOSPITAL, by Donald J. Mackintosh, M.V.O., M.B., LL.D., F.R.S.E., Second Edition, 1916. Edinburgh and London: William Hodge & Co.; Royal 8vo., pp. 155. Price, 15s.

PRINCIPLES AND PRACTICE OF OBSTETRICS, New (2nd Edition). Thoroughly Revised, by Joseph B. De Lee, A.M., M.D. Large octavo of 1087 pages, with 938 illustrations, 175 of them in colours; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Cloth, 38s 6d net.

A TEXT-BOOK OF PATHOLOGY, by Alfred Stengel, M.D., Professor of Medicine, and Herbert Fox, M.D. Sixth Edition, Reset. 8vo., of 1045 pages, with 468 text-illustrations, many in colours, and 15 coloured plates; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Cloth, 27s 6d net.

THE MEDICAL CLINICS OF CHICAGO, Volume I., Number II. (September, 1915). 8vo. of 194 pages, 44 illustrations; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Published Bi-Monthly. Price per year: Paper, 35s.

THE CLINICS OF JOHN B. MURPHY, M.D., at Mercy Hospital, Chicago. Volume IV., Number IV. (August, 1915). 8vo. of 216 pages, 40 illustrations; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Price per year: Paper, 35s.

DISEASE OF THE NOSE AND THROAT, by Algernon Coolidge, M.D. 12mo. of 360 pages, illustrated; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Cloth, 8s net.

AMERICAN ILLUSTRATED MEDICAL DICTIONARY (DORLAND), a new and complete dictionary of terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Veterinary Science, Nursing, Biology, and kindred branches; with new and elaborate tables. Eighth Revised Edition. Edited by W. A. Newman Dorland, M.D. Large octavo of 1135 pages, with 331 illustrations, 119 in colours. Containing over 1,500 more terms than the previous edition; 1915. Philadelphia and London: W. B. Saunders Company. Melbourne: James Little. Flexible Leather. 21s net.

SURGICAL NURSING AND TECHNIQUE, A BOOK FOR NURSES, DRESSERS, HOUSE SURGEONS, etc., by Charles P. Childe, B.A., F.R.C.S.; 1916. Baillière, Tindall and Cox. Second Edition. Crown 8vo., pp. 229. Illustrated. Price, 3s 6d.

PHYSIOLOGY FOR NURSES, by W. B. Drummond, M.B., C.M., F.R.C.P.; 1916. London: Edward Arnold. Crown, 8vo., pp. 210, with illustrations. Price, 2s 6d.

## Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xv.

Texas District Hospital, Queensland, Medical Officer.
Brisbane Hospital, Resident Medical Officer.
Hampden District Hospital, Resident Medical Officer.
Launceston General Hospital, Assistant House Surgeon.

## Medical Appointments.

### IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

| Branch. | APPOINTMENTS. |
|---|---|
| QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.) | Brisbane United F.S. Institute.<br>Croydon Hospital.<br>Laidley Hospital, Medical Officer. |
| WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.) | Swan District Medical Officer.<br>All Contract Practice Appointments in Western Australia. |
| SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.) | The F.S. Medical Assoc., Incorp., Adelaide. |
| NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.) | Department of Public Instruction—New Appointments as Medical Officer, Ophthalmic Surgeon, Ear, Nose and Throat Surgeon, Physician.<br>Australian Natives' Association.<br>Balmain United F.S. Dispensary.<br>Canterbury United F.S. Dispensary.<br>Goulburn F.S. Association.<br>Leichhardt and Petersham Dispensary.<br>M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney.<br>Marrickville United F.S. Dispensary.<br>N.S.W. Ambulance Association and Transport Brigade.<br>North Sydney United F.S.<br>People's Prudential Benefit Society.<br>Phœnix Mutual Provident Society.<br>F.S. Lodges at Casino.<br>F.S. Lodges at Lithgow.<br>F.S. Lodges at Orange.<br>F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe.<br>Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend. |
| NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.) | F.S. Lodges, Wellington, N.Z. |

## Diary for the Month.

Apr. 11.—Tas. Branch, B.M.A., Branch and Council.
Apr. 12.—North-East Med. Assoc. (N.S.W.), Annual Meeting, Lismore.
Apr. 13.—Vic. Branch, B.M.A., Council.
Apr. 13.—City Medical Assoc., General Meeting.
Apr. 14.—S. Aust. Branch, B.M.A., Council.
Apr. 14.—N.S.W Branch, BM.A., Clinical.
Apr. 15.—Northern Suburbs Med. Assoc. (N.S.W.).
Apr. 18.—Eastern Suburbs Med. Assoc.
Apr. 18.—N.S.W. Branch, B.M.A., Executive and Finance Committee, Ethics Committee.
Apr. 19.—W. Aust. Branch, B.M.A., General.
Apr. 19.—Western Suburbs Med. Assoc. (N.S.W.).
Apr. 20.—City Med. Assoc. (N.S.W).
Apr. 21.—Q. Branch, B.M.A., Council.
Apr. 25.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
Apr. 26.—Vic. Branch, B.M.A., Council.
Apr. 27.—St. Aust. Branch, B.M.A., Branch.
Apr. 28.—N.S.W. Branch, B.M.A., Ordinary.
May 3.—Cent. South. Med. Assoc. (N.S.W.).
May 3.—Cent. West. Med. Assoc. (N.S.W.).
May 5—Q. Branch, B.M.A., Branch.

### EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrury be stated.

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